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Pennsylvania Medicine

Volume 88, No. 7 JULY 1985

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Medigram—page 7
Liability Insurance Update—page 31

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*Kent JM, *et al: Patient Care* 17(19):181-217, Nov 15, 1983.

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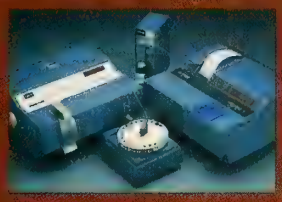

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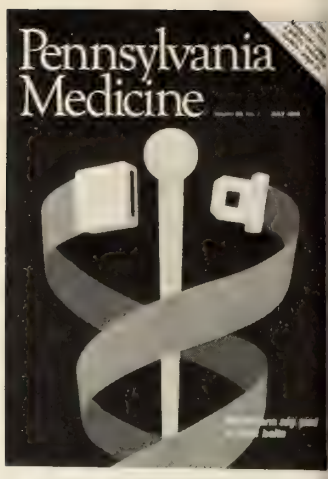

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EPRO CONTRACTS TO REVIEW EDICARE INPATIENT CARE

The Pennsylvania Medical Society's Keystone Peer Review Organization (KePRO) and the government's Health Care Financing Administration (HCFA) entered into a two-year, $20 million contract effective July 1. The $20,171,228 contract calls for the review of all hospitalizations of Medicare patients to assure quality of care, accuracy of diagnosis-related group assignment, and appropriateness of admission. The contract orders the completion of backlogged work in four and one half months; a revised technical plan in 30 days; preadmission review to start July 25, 1985; data system operational by August 15, 1985; and an initial evaluation after 15 months. KePRO's central office will be located in the Harrisburg area, with other offices in Norristown in the southeast and Monroeville in the west. Donald E. Harrop, MD, KePRO president, said the KePRO Board appointed Robert R. Weiser executive director.

YSICIAN FEES INCREASE NEW BUDGET IS SIGNED

An increase to 70 percent of average charges for physicians' office and hospital outpatient and emergency department visits was included in the state budget adopted and signed at the end of June. Of the $16 million assigned for increases in fees, $8 million is state money and $8 million is in matching federal funds. The legislature is in recess until September 18.

LPRACTICE OVERRIDES HER ISSUES AT SESSION

At the annual meeting of the AMA House of Delegates last month in Chicago, the professional liability insurance crisis overshadowed all other issues. Public health matters, including Acquired Immune Deficiency Syndrome (AIDS), smoking, and alcoholism, were paramount among scientific issues debated. Pennsylvania's 60 attendees included delegates, alternates, and representatives to the meeting of the Hospital Medical Staff Section which preceded the House of Delegates. A dues increase of $45 was approved. Effective in 1986, regular members will pay $375 dues a year. Those in their second year of practice, $281; those in their first year of practice, $187; and physicians in the military, $250. Dues for residents and medical students remain at $45 and $20 per year respectively. A Pennsylvania Delegation resolution advocating a change in the funding of health insurance was not adopted, but the concept was incorporated in a report on Medicare which was adopted. Edward H. Dench, Jr. MD, of State College, will serve another two-year term on the Governing Council of the Hospital Medical Staff Section. Honored at the opening ceremonies was Explorer Post 261, Braddock. Jeffrey Scripp, president, accepted an award for outstanding achievement in community service.

EGISLATURE ADOPTS EPORTING MEASURE

The House of Representatives on June 27 adopted Senate Bill 81, requiring the reporting of physicians, and returned it to the Senate for concurrence. The bill, which

then went to the Governor for his signature, requires ho pitals to report physicians to their respective licensi boards when their staff privileges are terminated because of malpractice or misconduct. This bill is the compani to a law passed earlier which gives the boards summa suspension authority (see page 37).

GOVERNOR SIGNS NEW LAW IMPROVING EMERGENCY CARE

Governor Dick Thornburgh signed legislation July 3 upgradi emergency medical services in Pennsylvania. The new l mandates that ambulance services meet minimum, national acceptable standards for staffing and equipment. It al gives continuity to the Pennsylvania Trauma Systems Found tion, which was due to expire June 30. Established la year with PMS support, the trauma foundation is charg with the accreditation of trauma centers throughout t state. The new law names the Department of Health as t lead agency for the development and maintenance of an eme gency medical system in the Commonwealth.

RABIES CASES MAINTAIN RECORD PACE IN STATE

The number of rabies cases in Pennsylvania during the firs half of 1985 is keeping pace with the record setting numb of 1984, the health department said. During the first s months of 1985, 137 cases were confirmed in 23 countie which is three more than were confirmed in the first ha of 1984. The center of the outbreak this year is Adams a Cumberland counties, with 42 and 27 confirmed cases respe tively. A total of 384 cases were confirmed in the sta in 1984, the highest number in 37 years.

COURT HOLDS OFF PAYMENT OF CHIROPRACTORS' CLAIMS

A state order requiring Pennsylvania Blue Shield to pay fo chiropractic service given to subscribers in large grou was put on hold June 20. Judge James Crumlish, Jr., Co monwealth Court, stayed the Insurance Department's ord given April 16 until the Court reaches a decision in Bl Shield's suit to have the order reversed. Blue Shield sa the order mandating payment to chiropractors would rai annual premiums more than $22 million. Judge Crumli wrote that Blue Shield showed "it will be irreparab harmed by being compelled to pay for chiropractic servic for contracting parties who have not paid premiums to cov the costs."

COLLECT MEDICARE COPAYS HCFA WARNS PHYSICIANS

The Health Care Financing Administration (HCFA), is alarme by a growing trend of some physicians and suppliers waive Medicare deductibles and coinsurance. HCFA has to carriers "... aggressively seek out instances of routi waiver and to make specific reductions in charge scree for these providers." Failure of physicians to ma efforts to collect deductibles and coinsurance is a viol tion of the Medicare law and is subject to a $2,000 fi per occurrence. James H. Sammons, MD, executive vi president of the AMA, protested HCFA's warning. "There a vast gulf between fraud and the compassionate waiver coinsurance and deductibles for patients in need," said. Still to be clarified is whether physicians m occassionally waive deductibles and coinsurance whe financial circumstances warrant it.

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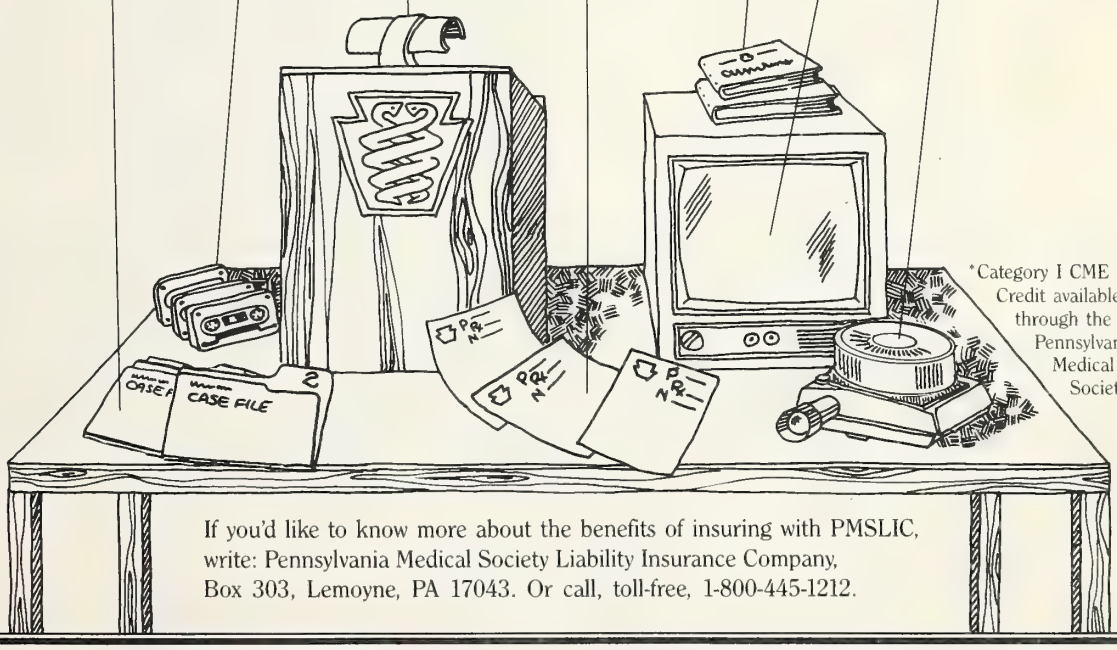

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editorial

In the best interest of the profession

On October 13, 1984, Health Care Financing Administration (HCFA) contracted with Pennsylvania Peer Review Organization (PaPRO) to review Medicare inpatient data throughout Pennsylvania for quality of care, accuracy of DRG assignment and appropriateness of admission. Early in 1985, HCFA withheld funding from PAPRO, thus effectively curtailing PaPRO operations. HCFA is currently searching for another peer review organization with which to enter into contractual agreement to replace PaPRO. The Pennsylvania Medical Society (PMS) has formed the Keystone Peer Review Organization, Inc. (KePRO) a corporation separate from PMS, to negotiate a PRO contract with HCFA.

Support for the PMS sponsored KePRO can be found in the mission statement of the Society as adopted February 4, 1981:

> The purpose of the Society shall be to federate the medical profession within the Commonwealth; to unite with similar medical organizations to form the AMA; *to represent the interests of the medical profession;* to promote and support the advancement of medical science and the extension of medical knowledge; to advance high standards of medical education; to uphold the ethics, integrity, and dignity of the medical profession; *to strive to make quality medical care available to the public; to advocate and support both public and private programs that will enhance the health and well-being of the public; to promote a professional, socioeconomic and political atmosphere conducive to quality care;* and to improve public understanding in regard to health."

KePRO would be a totally new organization, not a reorganization or modification of the old PaPRO. Basic principles would include strong central management; an optimal number of regional offices; excellent communication between physicians and hospitals and the PRO; and operational control and administrative support from PMS. KePRO would be an independent contractor, like a business, and would negotiate for the most advantageous monetary arrangement possible. Initially, a two year agreement would be conferred with renegotiation at the end of that period. The KePRO would continue if the arrangement proved satisfactory but would not be obliged to do so.

Organizers of the KePRO believe that communication with providers is of primary importance in achieving goals. It is believed that early communication of a reasonable objective, repeated often, will lead to nearly automatic compliance. By keeping providers informed and communications open, KePRO hopes to avoid retrospective denials of payment. Quality assurance of medical care is much more likely to be a priority in an organization directed by physicians. Objectives formulated by a provider-oriented program would strive to be cost efficient and at the same time, protective of medically necessary care.

Alternatives to KePRO are frightening. A PRO contractor could conceivably be outside the realm of medicine. For example, it could be an insurance company, which would qualify by relying on physician support or physician access groups to conduct reviews. While physicians would in fact be reviewing, the number would be much less representative of the profession and the "parent" contractor might not have a high priority on quality of care. The very real threat of cost cutting at any cost — even at the expense of quality — could surface in Pennsylvania.

Should PMS serve as the watchdog for quality of care? Our mission statement recognizes that we should. If, in guarding quality, we do so through a government sponsored program, does that deviate from the original intent? Will our activities in connection with HCFA in administering DRGs adversely affect the physician's image? If we avoid any commitment at all, will we do a disservice to the public which we serve? Will DRGs create difficulties in the future?

Some of these questions cannot be addressed because there just aren't any answers now. But there is a changing mood among physicians, who once felt that we should remain aloof from government, that now we can best influence government programs by being on the inside. The best result from the PaPRO experience may be that knowledgeable, reasonable physicians have an opportunity to decide the course of medical care for Pennsylvania.

David A. Smith, MD
Medical Editor

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Campaign begins for safety belt use law

The Keystone Safety Belt Network kicked off its campaign to pass a safety belt use law in Pennsylvania with a press conference in the Capitol Rotunda in Harrisburg.

Howard G. Hughes, MD, an emergency physician from Danville who opened the press conference, said, "From the perspective of an emergency physician, it is clear that Pennsylvania needs a safety belt use law. During 1984 in Pennsylvania, 881 people were killed in passenger car accidents, and 3,374 people were *seriously* injured. Good intentions aside, years of education and incentive programs have not worked, and right now, only 15 percent of Pennsylvania motorists wear their safety belts at any given time."

DR. HUGHES AT PRESS CONFERENCE

Dr. Hughes is the past president of the Pennsylvania chapter of the American College of Emergency Physicians, which along with the Pennsylvania Medical Society, is coordinating a statewide coalition, the Keystone Safety Belt Network, to work toward getting a belt use law passed in Pennsylvania.

Ten states already have passed safety belt use laws: New York, New Jersey, Indiana, Michigan, New Mexico, Texas, Illinois, Hawaii, Missouri, and North Carolina. The early results from New York, the first state to enact a law, are encouraging. The drop in fatalities and increase in belt use are dramatic. In the first month that fines were given, January 1985, there was a 38 percent reduction in occupant fatalities compared to January 1984. Seventy percent of New Yorkers are wearing their belts, compared to 15 percent prelaw.

Can we assume that the results would

Heart disease, cancer leading killers in state

While heart disease continues to be the number one killer in Pennsylvania, the death rate from cancer has reached the highest ever recorded.

According to the recently published report, *Pennsylvania Vital Statistics 1983*, the leading cause of death that year was heart disease, accounting for 49,780 or 41.1 percent of all 121,066 deaths. The ranking of this, as well as the next three leading causes of death, has remained constant since 1950 and together accounted for nearly three-quarters of all deaths in 1983.

The second leading cause of death was cancer, accounting for 26,917 deaths. The cancer death rate—226.3 per 100,000 population—was the highest ever recorded in Pennsylvania. The next highest was the rate of 222.8 recorded in 1982.

The third leading cause of death was cerebrovascular disease (stroke), accounting for 8,384 deaths, and accidents, the fourth leading cause, accounted for 4,147 deaths.

The fifth leading cause of death, chronic obstructive lung disease, is a relatively new category that includes bronchitis, emphysema, asthma, and related conditions. It accounted for 3,521 deaths in 1983.

The remaining top ten causes of death, and the number of 1983 deaths, are as follows: pneumonia/influenza, 2,651; diabetes, 2,502; atherosclerosis, 1,451; liver disease and cirrhosis, 1,371; and suicide, 1,340.

The report noted that causes of death varied widely among different age groups. For children under 5 years of age, deaths in 1983 were due mainly to early infancy problems (43 percent), birth defects (21.9 percent), and accidents (6.3 percent). This age group accounted for 2,056 deaths in 1983.

For those aged 5 to 24 years of age, accidents caused half of all deaths. Motor vehicle accidents alone accounted for 34.9 percent of the deaths, suicide for 12.2 percent, cancer for 8.6 percent, and homicide for 8.4 percent. A total of 1,946 deaths was recorded for this age group.

There were 4,697 deaths among those 25 to 44 years of age, broken down as follows: accidents, 21 percent; cancer, 19.4 percent; heart disease, 16.5 percent; and suicide, 10.6 percent.

For the age group 45-64, nearly 70 percent of the deaths were due to heart disease (35.2 percent) and cancer (34.4 percent). Stroke was a distant third, accounting for 3.8 percent of the 24,247 deaths in this group.

Heart disease accounted for over 43 percent of the deaths for persons aged 65 through 84. Cancer accounted for over 23 percent, and stroke for 7.5 percent. There were 64,406 deaths in this age group.

For the age group 85 years and older, 52.2 percent of the deaths were from heart disease, 10.7 percent from cancer, 10.3 percent from stroke, and 4.4 percent from pneumonia or influenza. This age group accounted for 23,712 deaths, the report said.

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be the same in Pennsylvania? "Yes," according to Dr. Hughes. "The results of a survey that PaACEP (Pennsylvania Chapter, American College of Emergency Physicians) commissioned in April, 1985, are in: Seventy percent of the Pennsylvanians asked would support legislation in Pennsylvania requiring front seat passengers to wear safety belts. In fact, over half of the respondents—56 percent—said they would 'strongly support' the proposed legislation." PaACEP's survey was conducted by Tarrance & Associates, Houston, Texas, one of the major public opinion research firms in the country.

"Part of the reason we are here today," explained Dr. Hughes, "is because of the bills which have been introduced into our State Legislature—three in the Senate and one in the House. I urge the Pennsylvania Legislature to act quickly upon these bills so that we may soon have a law that will make our roadways safer."

Two people who survived car accidents told their stories at the press conference, Pam Gardner of Lewisberry and Cynthia Houtz of Newberrytown.

Some see this legislation as government intrusion. People say, "My safety is my business, not the government's." Dr. Huges responds, "Our survey shows that Pennsylvanians feel that safety belts save lives and that everyone should buckle up. Not only should everyone buckle up, but Pennsylvanians support a law requiring everyone to buckle up.

"Operating a motor vehicle and use of state roads is regulated by the government through the driver licensing system, traffic laws, and vehicle standards. A belt use law should be required in the same context. Driving an automobile is a privilege, not a right. Traffic accidents do not happen on personal streets and highways. Our tax money provides the emergency services required after a collision. Public health and welfare agencies are called upon to provide permanent health and welfare services made necessary by an accident. Safety on the highways is not personal. It is everyone's business."

This legislation is a natural extension of the child passenger protection act which recently became law in Pennsylvania.

Summary of seat belt bills

To date, four seat belt bills have been introduced.

SB-121 Introduced by Senator Edward M. Early (D-Allegheny/Armstrong/Westmoreland)

Main features:
- Driver and front seat passengers to use safety belts
- Driver responsible for occupants
- Medical exemption
- $25 fine

SB-122 Introduced by Senator Edward M. Early

Main features:
- Mandatory seat belt use for driver and front seat passengers
- Driver responsible for occupants
- Rear seat passengers less than ten years old must use safety belts
- Exemption for certified medical reasons
- $25 fine
- Violation not admitted on issue of liability, but can be used for mitigation of damages
- One month warning period

HB-105 Introduced by Representative Peter R. Vroon (R-Chester/Montgomery)

Main features:
- Driver and front seat passengers to use safety belts
- Driver responsible for occupants
- Exemption for certified medical reasons
- $25 fine
- Fines collected to be deposited in Catastrophic Loss Trust Fund

SB-831 Introduced by J. Doyle Corman Jr. (R-Cameron, Centre, Clinton, Mifflin, and parts of Clearfield and Juniata)

Main features:
- All passengers are required to use safety belts
- Applies to a passenger car or any vehicle within range of weights for class 1 and class 2 trucks
- Vehicles used exclusively for commercial deliveries exempt
- Exemption for certified medical reasons
- Failure to wear safety belt shall be admissible to mitigate damages if testimony shows a causal relationship between nonuse of safety belts and injuries
- $20 fine
- A 10 percent premium reduction in personal motor vehicle liability insurance policy for first-party benefits to any vehicle equipped with an air bag
- Enactment would not be used in any manner to rescind federal automatic crash protection system requirements
- The Insurance Commissioner and Secretary of Health, within 18 months of effective date, shall issue a report on the use of seat belts, death and injury rate, and severity of insurance claims.

State sets guidelines for ambulatory surgery

The Pennsylvania Department of Health has promulgated guidelines on certificate of need for ambulatory surgery centers.

1. There is established a new 50 percent threshold for ambulatory surgery. If ambulatory surgery makes up less than half of all surgery performed in a health service area, the health department will consider applications for ambulatory centers. Surgery performed in physicians' offices will not be included for this purpose.

2. Equal consideration will be given to: hospitals with full capacity (ORs in use more than 80 percent of the time); hospitals with excess capacity if the hospital closes one traditional OR for every new ambulatory surgery room approved; and independent, freestanding facilities.

3. Priority will be given to applications which will reduce the cost of current inpatient surgery by an amount greater than that requested for the new facility; reduce the number of beds along with surgical capacity; guarantee charges by procedure for at least two years; and agree not to change ownership for at least two years.

Daniel H. Brooks, MD, of Sewickley represented PMS on the task force which developed the guidelines.

BALANCED CALCIUM CHANNEL BLOCKADE!

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

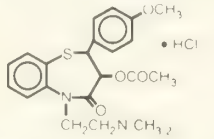
Please see full prescribing information on following page.

2/84

PROFESSIONAL USE INFORMATION

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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State's medical schools award 1,259 degrees

Karen K. Davis

1,259 new physicians were awarded legrees by the state's seven medical chools and one osteopathic college at eremonies in May and June. This repesents a three percent decrease from ast year when 1,297 students received MD or DO degrees. While the total ıumber of graduates decreased, the ıumber of women receiving degrees inreased three percent over last year. 374 vomen were awarded degrees this year, vhile 349 women received degrees in 984.

Comedian and actor Bill Cosby received the first Honorary Medical Alumnus Award from Temple University School of Medicine for his positive portrayal of the medical profession as Dr. Cliff Huxtable on "The Cosby Show" (NBC). The award was presented as part of the university's commencement program. Shown above, from left, are Sol Sherry, MD; Cosby; Peter J. Liacouras; and Frederick Sutliff, MD. Dr. Sherry is dean of the school of medicine, Liacouras is president of the university, and Dr. Sutliff is president of the Medical Alumni Association.

Hahnemann University School of Medicine

Hahnemann University awarded a total of 167 degrees to 130 men and 37 women at the 138th commencement, June 6, 1985. Exercises began at 2:30 p.m. at the Academy of Music, Philadelphia.

Robert K. Jarvik, MD, inventor of the JARVIK-7™ artificial heart, addressed the graduates. Dr. Jarvik is assistant research professor at the University of Utah College of Medicine, Salt Lake City, and is responsible for research on the electrohydraulic heart. Besides the artifical heart, he also is involved in designing advanced products such as implanted electrode components of the artificial ear. Dr. Jarvik earned a master of arts degree in occupational biomechanics from New York University, and a medical degree from the University of Utah College of Medicine.

Honorary degrees were presented to Dr. Jarvik, who was awarded an honorary Doctor of Science degree, as well as three other physicians. William Likoff, MD, chancellor of Hahnemann University, received an honorary Doctor of Science degree. Maurice C. Clifford, MD, president of Medical College of Pennsylvania, and Edward M. Snider, owner of the Philadelphia Flyers professional hockey team, were given honorary Doctorates of Humane Letters. In addition, Hahnemann's highest honor, the University Medal, was presented to Charles P. Bailey, MD, JD, clinical professor of medicine at Hahnemann, who in 1948 performed the world's first successful valvular surgery within the human heart.

On June 5th, the afternoon before the commencement exercises, Drs. Jarvik and Bailey were the main speakers at a symposium on "Heart disease—past, present, and future." The symposium was sponsored by Likoff Cardiovascular Institute of Hahnemann University.

Jefferson Medical College of Thomas Jefferson University

Jefferson Medical College of Thomas Jefferson University conferred 211 degrees on 165 men and 46 women at its 161st commencement on June 7, 1985. The exercises began at 10 a.m. at the Academy of Music, Philadelphia.

William B. Bean, MD; and W. Paul Havens Jr., MD, spoke at the ceremony. Dr. Bean, Sir William Osler Professor of Medicine at University of Iowa College of Medicine, is an authority on medical history. He has researched the life of Dr. Robley Dunglison, personal physician to Thomas Jefferson and dean of Jefferson Medical College from 1854 to 1868. Dr. Havens, honorary professor of medicine at Jefferson, was involved in research of the hepatitis virus and won the Army's commendation medal for his work in this area. He has been a member of the Jefferson faculty since 1946.

Dr. Bean was awarded an honorary Doctor of Humane Letters degree, and Dr. Havens received an honorary Doctorate of Science.

Medical College of Pennsylvania

At the 133rd commencement of the Medical College of Pennsylvania, 119 degrees were awarded to 54 men and 65 women. The exercises were held May 29, 1985, at 10:30 a.m. in the Academy of Music, Philadelphia.

Eric J. Cassell, MD, FACP, gave the commencement address. An author and humanist in medicine, Dr. Cassell is clinical professor of public health at Cornell University Medical College and director of Cornell's program for the study of ethics and values in medicine. He wrote *Talking With Patients*, a two volume work on communication between physicians and patients.

Dr. Cassell received an honorary Doctor of Humane Letters degree. Five other honorary degrees were awarded at the ceremony. Mary Patterson McPherson, PhD; and Audrey Meyer Mars were awarded honorary Doctorates of Humane Letters. Dr. McPherson is president of Bryn Mawr College. She has been a board member of numerous corporations and institutions, including the Committee to Support Philadelphia Public Schools. The Medical College of Pennsylvania maintains a joint admissions program with Bryn Mawr Col-

lege. Audrey Mars, of Washington, DC, is a member of the Medical College of Pennsylvania's national board. She is a former board member of Mars, Inc.

Leonard T. Ebert and John W. McPherson III, Esq., were given honorary Doctor of Laws degrees. Leonard Ebert served as president of PSFS (formerly Philadelphia Savings Fund Society) until 1984. Currently, he is chief executive officer of PSFS Savings Bank. He is a member of the medical college's Board of Corporators and chairman of the college's finance committee and investment board. John McPherson, cousin of honorary degree recipient Dr. Mary McPherson, is a retired attorney. He has served on the college's Board of Corporators since 1941.

An honorary Doctor of Medical Science degree was presented to David Satchner, MD, PhD, president of Meharry Medical College, Tennessee. Dr. Satchner is current president of the Association of Minority Health Professions Schools.

Pennsylvania State University College of Medicine

96 medical degrees were awarded to 60 men and 36 women at the 15th commencement of the Pennsylvania State University College of Medicine in Hershey. The exercises took place May 19, 1985, at 2 p.m. in Founders Hall, Hershey.

William G. Anlyan, MD, chancellor for health affairs at Duke University School of Medicine, delivered the commencement address. Before becoming chancellor, Dr. Anlyan served for 14 years as vice chancellor and professor of medicine at Duke. He is former chairman of the Association of American Medical Colleges.

Harry Prystowsky, MD, dean of the college of medicine and senior vice president for health affairs, directed the commencement ceremony. George Garrow, MD, offered remarks on behalf of the graduating class.

Philadelphia College of Osteopathic Medicine

205 doctor of osteopathy degrees were conferred on 166 men and 39 women at the 94th commencement of Philadelphia College of Osteopathic Medicine (PCOM). Exercises began at 3 p.m. on June 2, 1985, at the Academy of Music, Philadelphia.

The Honorable J. Sidney Hoffman, chairman of the college's board of trustees, spoke at the ceremony. Judge Hoffman also administered the oath of office to incoming president J. Peter Tilley, DO. Dr. Tilley, the fifth president of the college, is a specialist in radiology and nuclear medicine. A graduate of Kirksville College of Osteopathic Medicine, Missouri, he has served as a faculty member at PCOM for 19 years.

The college presented an honorary Doctor of Laws degree to Dr. Tilley, and to Herman Kohn, DO. Dr. Kohn is a 1927 graduate of PCOM; he has served for 36 years on the college's board of trustees; and he is professor emeritus of surgery.

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Temple University School of Medicine

Temple University School of Medicine awarded 176 degrees to 117 men and 59 women at its 81st commencement, May 23, 1985. The medical degrees were presented at the Academy of Music during a separate ceremony following the university's 99th general exercises at Convention Hall, Philadelphia.

Francis J. Sweeney, MD, the university's vice president of health sciences, and Sol Sherry, MD, dean of the medical school, presided at the medical school ceremony.

School officials report that nearly 60 percent of the 176 new physicians receiving degrees from Temple will begin careers in a specialty that deals directly with patient care. Of the graduates, 101 will enter residencies in internal medicine, family practice, pediatrics, obstetrics and gynecology, or emergency medicine. Another 52, or 29 percent, will begin training in surgery. In addition, 56 percent will remain in Pennsylvania to provide service.

University of Pennsylvania School of Medicine

95 men and 53 women earned medical degrees from University of Pennsylvania School of Medicine. The 148 degrees were presented at a special ceremony at 4 p.m. on May 20, 1985. The diploma ceremony, which followed the university's general commencement exercises at the Philadelphia Civic Center, was held on campus in Irvine Auditorium.

Luigi Mastroianni Jr., MD, addressed the graduating class. Dr. Mastroianni is chairman and William Goodelle Professor of Obstetrics and Gynecology at University of Pennsylvania School of Medicine.

University of Pittsburgh School of Medicine

The University of Pittsburgh School of Medicine conferred 137 degrees on 98 men and 39 women at a ceremony on May 28, 1985, at Carnegie Music Hall, Pittsburgh. This was the 99th time the school awarded medical degrees.

Mark M. Ravitch, MD, professor of surgery at the medical school and surgeon in chief at Montifiore Hospital, addressed the graduates. David J. Kupfer, MD, professor of psychiatry and chairman of the school's psychiatry department, gave closing remarks. Degrees were presented by Thomas Detre, MD, senior vice president of the university's schools of the health sciences.

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Passport tracks elderly patients' drug use

Three Pennsylvania organizations have developed the "Medication Passport" for senior citizens to help them keep track of the medications they are taking. The passports have a space for recording both prescription and over-the-counter drugs. In order to avoid adverse drug reactions, the physician, the pharmacist, and the patient can use the passport to record and check the various drugs used. The three sponsoring groups are the state Department of Aging, the Pennsylvania Pharmaceutical Association, and the Blue Cross and Blue Shield plans of Pennsylvania.

Initially, one million copies of the Medication Passport will be printed and distributed. The passports will be made available to Pennsylvania's senior citizens through 2,800 pharmacies that work with the state's PACE (Pharmaceutical Assistance Contract for the Elderly) program, through area agencies on aging, and through the Department of Aging. In addition, Blue Shield will provide passport samples to 10,000 physicians who regularly treat senior citizens.

The red and gold pocket-sized passport includes pages for personal and medical information, and log space for recording all drugs. A Medication Passport logo will be visible at pharmacies participating in the program. Promotional posters and materials are available for pharmacies, physicians, and senior citizens' centers.

There are more than 38 million senior citizens (over 60) in the U.S., and 2.2 million in Pennsylvania, the fourth "oldest" state in the country. In Pennsylvania, the senior citizen population accounts for 18.1 percent of all residents.

Adverse drug reactions affect nearly a third of Pennsylvania's senior citizens and result in unanticipated suffering, caused by the very medications intended to help reduce suffering, a report from the sponsoring agencies said. The aging process brings with it chronic illnesses that require medical and medicinal attention. More than 75 percent of Pennsylvania's senior citizens have chronic illnesses and take prescription medications to deal with their illnesses.

The report said the average elderly person in the U.S. spends $73.30 each year on more than 14 prescriptions, and a large group of more than four million senior citizens spends $250 or more each year on their medications. In Pennsylvania, an estimated 300,000 people fall in the latter category. Above that average of $73.30, each person will spend another $40 or $50 on over-the-counter drugs and $20 to $25 on miscellaneous medical items.

In his recent speech to the National Pharmaceutical Council, Frank E. Young, MD, PhD, commissioner of the federal Food and Drug Administration, said, "In my years as a practicing physician, I've seen that many patients have difficulty monitoring and maintaining records of their medications. A 'medical log,' made available to patients, would provide a simple way for them to keep track of medications they are taking. It would also serve as a consistent record to be shared among a number of health care professionals." The Medication Passport provides this service for Pennsylvanians.

Variables in drug therapy for senior citizens

- The elderly generally are more responsive to drugs.
- Studies have demonstrated fluctuating absorption levels among senior citizens.
- The distribution of drugs to the body systems changes with age. Drugs tend to seek out fatty tissue, which older people have in increasing proportions; therefore, prescribed doses can be ineffective or unpredictable.
- Serum albumin declines among older people, releasing more unbound active drug in an unpredictable manner.
- Metabolism is complex and individualized.
- Kidneys are less active, so drugs do not clear the body at the same rate as in younger people.
- Drug receptor sites change.
- Stress response among senior citizens slows significantly, and general body responses are slower.

These variables, along with the potential for multiple drug interaction and drug-food interaction, lead to the need for personalized approaches to prescribing treatment for older people.

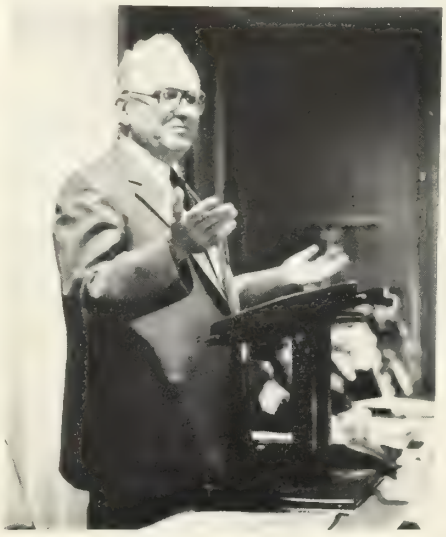
Health writers study current health care issues

Reporters from across the state came to Harrisburg in May for the fourth Health Care Writers' Seminar. The program was sponsored by PMS and the Hospital Association of Pennsylvania.

The reporters heard a presentation by health care economist and writer Harry Schwartz, PhD. Dr. Schwartz currently is writer in residence at the College of Physicians and Surgeons of Columbia University. He writes for PENNSYLVANIA MEDICINE, and has published articles on health-related matters in *The New York Times, Wall Street Journal, New England Journal of Medicine,* and *Medical Economics.*

The first day's program also included a panel on various types of health care reporting.

The second day featured presentations by physicians and hospital officials on current issues in health care, such as marketing, uncompensated care, ethical questions, trauma center accreditation, and teenage suicide. The conference concluded with an address by H. Arnold Muller, MD, state secretary of health.



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Federal official discusses medical student aid

Karen K. Davis

An expert in the field of financing education for health professionals recently visited Pennsylvania with some new ideas for this now near impossible task. "I have worked since 1969 with the federal health professions (student assistance) programs, and I have watched the evolution and the changes occurring since that time," said Alice M. Swift, deputy director of the division of student assistance for the federal bureau of health professions. This bureau is part of the U. S. Department of Health and Human Services.

Alice Swift recently came to the Society's headquarters in Lemoyne to speak at the 12th Annual Financial Aid Officers' Workshop, sponsored by the Educational and Scientific Trust of PMS. She talked to the attending medical school aid officers about federal legislation and how it will affect financial assistance given to people studying to be physicians. After the workshop sessions, she drew on her 16 years of experience to make some personal comments about the assistance programs today.

Because the cost of medical education is considerable, the federal government developed scholarships and loans to help students afford it. Swift gave some background on the programs. "Legislation was passed in 1963, and these programs were started in 1964. In 1969, (the year she came to the Department of Health, Education, and Welfare in Washington) there were four different student support activities. They had a health professions student loan program, a health professions scholarship program, nursing student loans, and nursing scholarships."

Later, Congress allotted money for the National Health Service Corps scholarship, which at that time we administered in our division, she said. "In this program, students were supported in return for a year of service in an underserved area after they finished school. This had its peak years in the mid to late 70s and then started to slow down in the 80s."

Today, the division administers three programs, she continued. One is a scholarship for first year medical students. "It is very limited—some years we give only one per medical school; some years the schools may get as many as two or three, but it is a full scholarship for the first year of study without any payback provisions at all.

"Next," she said, "there is the health professions student loan, which is a long term, low interest loan adapted to meet the needs of medical students. It allows repayment to be deferred until they finish advanced professional training. This program is one of the first, enacted back in 1963. Money from that first program is still there revolving in the schools today. That's the money the division is administering, because we have not had new appropriations for several years. We administer only those funds that are revolving—from prior loans made to students and collection of principal and interest from them," she said.

"In the late 70s, the private sector was brought into play with the HEAL (Health Education Assistance Loan) program. The HEAL is guaranteed by the federal government and available through the private market—credit unions, banks, and other kinds of financial institutions are lenders. Students pay an insurance premium which supports any default that may result. Because it is guaranteed by the federal government, it is a no-risk loan for the lender," she explained. "This program has the largest amount of money available to students, who can borrow up to $80,000 in four years, and although the lender defers payment while the student is in medical school and training, the interest (figured at market rates) accrues and is compounded semi-annually. So it becomes a very, very expensive program," Swift said.

Current issues such as physician supply and the national deficit are affecting student assistance, she said, and government officials are reevaluating the role the loan programs play. "We have to cut; we are in a situation where we have to do something about our deficits, and we must look at all the programs, many of which have been very valuable, and say which we can do without. Fortunately, we do have money revolving in the schools so that new appropriations are not required to continue the loan programs.

"I think in any large loan program, whether it's federal or private there will be some abuses," Swift said. "The more experienced and respected a school's financial aid officer is, and the stronger the school's policies, the better the chances of cutting out abuses. I would

The Educational and Scientific Trust of PMS sponsored its 12th Annual Financial Aid Officers Workshop in May. At the workshop, checks from the American Medical Association's Education Research Foundation (AMA-ERF) were distributed to financial aid officers from the state's medical schools. The checks totalled more than $83,000. Above, John Rineman, Executive Vice President of PMS, presents a check to Joann Craig, financial aid officer at University of Pennsylvania School of Medicine.

ay there have been more abuses in the ast than there are in the present, but here's always going to be somebody rying to beat the system; there's no ay to get around that.

"Also, there is a strong tendency on he part of the students to say 'I am an dult, responsible for myself, and I do ot need my parents for support.' They on't see these programs as supplehents. I think a student's financial suport is still the family's responsibility. Vhen students don't use the resources hey have, I think they're being abusive o the system."

Vew concept for funding

Stepping out of her role as a federal dministrator, Alice Swift explained a iew idea she has to take funding for hysicians' educations out of the hands f government. "I think it's feasible for he private sector to support this educaion totally," she said. "My concept is to ave foundations as the lenders. They vould start lending money to the igher level students (in their third and ourth years) to get money coming back n as soon as possible. Then, as the program builds, support for second and irst year students could be added.

"As this program is being built up, he other programs would gradually be hased out, and the young professional vorld would be supporting the educaion program based from the seed money the foundation provided. A fund would be created, and money given out based on need.

"This is not an impossible dream; I think it is a realistic dream," Swift emphasized. "It would take a number of years to develop, just as it has taken directors of the federal program a number of years to get the revolving fund in place. The private sector would use federal money until it could take over completely. Federal funds would be a stepping stone to private initiative." Having the program in the private sector would also eliminate the flux in the current system caused by the change in government priorities, said Swift.

This concept is her own vision for the future, based on her work with the programs in the past. "What it really amounts to," said Swift, "is a program of physicians supporting physicians."

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'Right to die' topic of MCMS program

U. B. Ellis, Ed D

"Right to Die" was the topic of the Tenth Annual Montgomery County Medical Society (MCMS) Auxiliary and Legislators Luncheon held at Sacred Heart Hospital, Norristown, in April. 85 people, including physicians, auxiliary members, legislators, nurses, clergy, hospital administrators, and trustees listened to a panel discussion on this critical, emotional issue. A physician, a lawyer, and a legislator participated on the panel.

Marvin H. Marx, MD, president of MCMS, opened the program. "We doctors basically have two concerns," he said. "One of them is that we do not like to play God. The other is facing malpractice liability and a possible charge of murder."

Alan L. Dorian, MD, chairman of the county society's Medical-Legal Committee, and moderator for the panel, started the discussion by reciting from Dylan Thomas:

"Do not go gentle into that good night,
Old age should burn and rave at close of day,
Rage, rage against the dying of the light."

"While many may be tired of hearing about the 'right to die,' " he said, "It continues to be a burning issue for physicians of the critically ill, and the surgeons assigned to hospital trauma centers.

"The issue also affects nurses," he continued. "At Sacred Heart Hospital each year nurses request transfers out of the intensive care units. They complain they are suffering from burn-out."

The first panelist, Frank J. Tornetta, MD, chief of anesthesiology at Montgomery Hospital, gave "four reasons physicians, patients, and family have found themselves faced with this serious ethical decision: the advancement of medical care in recent years; longer life spans, reaching 75 years; an increased number of people dying in hospitals; and a growing awareness of human rights issues."

Dr. Tornetta said, "Medicine has improved the average life span, but has done nothing to improve the process of aging." He said physicians face a dilemma because "their extensive training gears them only toward saving life, and their Hippocratic Oath forbids them to do anything that would take a life."

He emphasized medicine is not an exact science. The nation's legal system has lagged in development of a concise formula with which physicians and family can face the death of loved ones. Dr. Tornetta concurred with Dr. Marx that doctors are in constant worry of litigation resulting from foregoing life-sustaining treatment for the terminally ill.

Francis P. O'Hara, Esq., solicitor for Sacred Heart Hospital, described the difficulties hospital administrators, staff, and family members have experienced with right to die decisions. He said, "for each complex problem someone always has an answer that is simple, neat . . . and wrong."

He warned that "law does not allow a person the right to decide to die; it does not sanction suicide. But one does have the right to determine if he or she wishes to undergo a medical treatment that may prolong life. If the medical treatment is refused, and death occurs, the death would be the result of the underlying medical problem, and not the patient's decision that he or she wished to die."

Attorney O'Hara said he believes the right to die issue can be resolved in Pennsylvania only through a joint effort by the medical society and the bar association. They must study all aspects of the problem, going to the community to consult with families, clergy, and others before drafting legislation.

Joseph Lashinger, State Representative for the 150th District, assured the audience the legislators have concerns over the right to die issue. He reminded everyone that legislators recently passed a bill defining when a person may be declared legally dead. He supported the plea for legislation to protect physicians, hospitals, and families in right to die situations.

At the conclusion of the panel presentation, questions and statements from the audience supported the request for legislation to provide immunity for the physicians, hospitals, and family members after their joint decisions and actions related to a patient's right to die.

Dr. Dorian said, "We hope some day we can rewrite Dylan Thomas' words and say, *go gentle* into that good night."

MCMS holds a legislative luncheon every year. For a description of their program, and tips on instituting similar meetings, see PENNSYLVANIA MEDICINE, December 1983.

1984 was the sixth consecutive year that Pennsylvania Medical Society increased its membership in the American Medical Association. Society President D. Ernest Witt, MD, (left) accepted a plaque in recognition of this achievement from John J. Coury Jr., MD, chairman of the AMA's Board of Trustees.

The author is the executive director of Montgomery County Medical Society.

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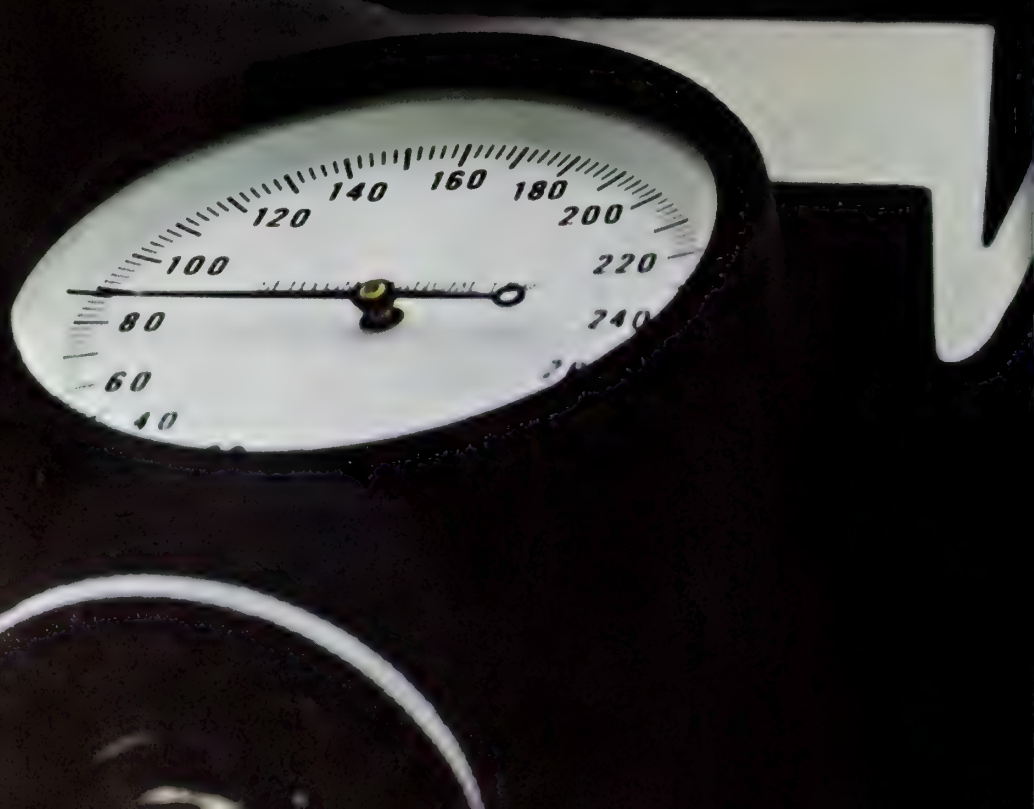

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Please see brief summary of prescribing information on the next page for further details

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia; congestive heart failure, intensification of AV block; hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Free publications

The following publications are available on request for a limited time:

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- "AMA Diagnostic and Treatment Guidelines Concerning Child Abuse and Neglect," a 35 page pamphlet
- "What Should I Know About Medications?" a pamphlet produced for older Pennsylvanians by the Pennsylvania Department of Aging, available in quantity for distribution to patients

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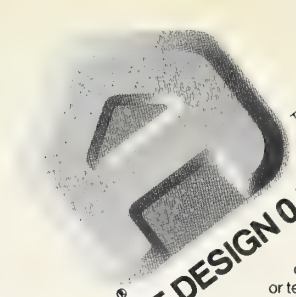

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DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® IV for Anxiety (lorazepam)

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

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no significant changes in vital signs in cardiovascular patients*

short duration of action, simple metabolism

*Benzodiazepines have not been shown to be of benefit in treating the cardiovascular component.

See important information on preceding page.

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special feature

In liability insurance, complexities abound

Ten years have passed since the crisis in the availability of medical professional liability insurance. Since then much has changed, but not necessarily for the better as this exclusive interview reveals.

Eight years ago, when the Pennsylvania Medical Society was forced to found a new company just so members would have a source for malpractice insurance, life was not easy, but it was simpler. Today life is still not easy and in reference to professional liability insurance, it is anything but simple. PENNSYLVANIA MEDICINE, in order to describe the current climate, interviewed A. John Smither, president and chief operating officer of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC). Active in the insurance business for more than 37 years—a career diversified among company, broker, and regulatory sectors, he has spent the last 16 years exclusively in the medical professional liability field. He assumed his current position with PMSLIC on November 20, 1978. Managing Editor Mary Uehlein posed the questions.

Q. *John, you actively assisted the Pennsylvania Medical Society in the formation of PMSLIC, so you're very familiar with the events which led to its inception. What was the state of the insurance marketplace in the fall of 1977 when the company was capitalized?*

A. Argonaut was poised to abandon approximately 4,700 PMS member policyholders whose only recourse at that time for replacement coverage was the Joint Underwriting Association (JUA), a quasi-governmental mechanism created in 1976 as a residual market of last resort. There were no other carriers interested in picking up where Argonaut left off and the influx of many high-risk surgeons from Argonaut to the JUA could have triggered a little known provision of Act 111, endowing the JUA with a virtual malpractice insurance monopoly as respects all physicians practicing in Pennsylvania. If that had happened, the Medical Protective Company, the only major commercial carrier then remaining in Pennsylvania, would have been forced to cease its operations and its 6,000 policyholders, along with any physicians then insured through hospitals or under national specialty programs, would have had to follow Argonaut's policyholders into the JUA. The timely formation of PMSLIC saved the day, not only for the abandoned Argonaut insureds, but for all other doctors—many of whom until then assumed that they were insulated from that crisis of insurance availability. It is to the everlasting credit of the Pennsylvania Medical Society, through its members, that the challenge was accepted and met.

Q. *In the more than seven years that PMSLIC has been operating, has the marketplace for medical malpractice insurance changed?*

A. It certainly has. In fact, it has gone the full circle! As I've already indicated, absent the formation of PMSLIC, there were no carriers willing to write the business. Now we have a marketplace which Professors Hofflander and Nye describe, in the report entitled "Medical Malpractice Insurance in Pennsylvania," as being in a "state of chronic potential oversupply." Obviously, this is a totally different situation from 1977 but one which carries the potential for even more serious problems in the future.

Q. *That's confusing. Doesn't an "oversupply" of any goods or services generally mean a break for the consumer through lower prices? Why should the situation be different for professional liability insurance?*

A. Because insurance is unlike any other product offered for sale. You can have a dozen manufacturers of, say, a "widget" competing with one another, each trying to get a larger share of the

market through the simple expediency of reducing their prices below those of their competitors. This scenario produces a market in which widgets are readily available, generally at no sacrifice in quality and at great savings to the consumer. When as a result of the price war, some of the widget manufacturers begin to lose money, they likely will cease making that particular product in favor of another which still has a profit potential. Some businesses will actually fold and enter bankruptcy. Except for the employees, shareholders and creditors involved, no consumers will have been hurt by such a chain of events because they have intact what they paid for. Insurance, on the other hand, represents a fiduciary product. Premium is exchanged now for the promise of defense and indemnity costs later, if and when needed—perhaps years later—and the insurance company which charges too little now in order to buy into the marketplace may not be around to fulfill its fiduciary responsibility when the time comes. While a doctor may complain, and understandably so, at today's cost of malpractice insurance, even worse than a premium that is perceived as too high is a policy purchased at a "bargain" rate with a company which is no longer financially able to honor its contract. The buyer's market to which I referred in the widget example becomes a "buyer beware" market, where the product is an intangible such as malpractice insurance, and the consumer accepts an enormous long-term risk in order to save dollars up front if he or she elects to purchase coverage with a company whose premiums are substantially lower than those being charged by the majority of established companies.

Q. *John, doesn't the fact that medical malpractice insurance is a "long tail" line give a pricing edge to a company newly entering the marketplace, insofar as during its initial years few claims or suits are likely to be reported, thus enabling lower premiums to be charged?*

A. Mary, the situation you have described represents one of the most common myths about our business. In fact, in the spring issue of "Pulse," the quarterly publication which goes to all PMSLIC policyholders, the chairman of our Board, Dr. David S. Masland, addressed this common misconception in detail. Put as simply as possible, all insurance companies are governed by the same rate-making and reserving process, imposed by the various insurance regulatory authorities by way of the statutory accounting principles to which all companies must adhere. Basic to such principles is the "fully funded" liability concept. This requires a company from the day it collects its first premium and issues its first policy to escrow, or "reserve," a certain portion of that premium to cover its predictable losses. Such reserves must be sufficient to cover not only the indemnity and settlement costs associated with those claims actually reported in any policy year, but also those which statistics predict will be incurred during the same policy period but which will not be reported to the company until later. In other words, the "fully funded" concept puts an equal burden on all companies, new or old, to allocate from their inception adequate reserves, including reserves for those losses yet unreported. A company which ignores this concept for the purposes of its own immediate growth does so at its long-term peril and the physician who accepts that company's "cut-rate" premium offering is to some extent playing Russian Roulette with his or her future security.

Premium increases for PMSLIC coverage since 1978 have averaged 6.1 percent annually, barely matching the rate of inflation.

Q. *John, most Pennsylvania physicians and many observers outside of the profession have concluded that another medical malpractice crisis is upon us—this time not one of availability but one of cost. PMSLIC's premiums right now are second only to those charged by the JUA. This is a source of great frustration to most phyicians, particularly those who helped capitalize PMSLIC back in 1977 and who assumed that a physician-owned and directed company, being run on a not-for-profit basis, would be able to offer rates lower than any commercial carrier. Why hasn't this happened?*

A. Mary, any policyholder who is frustrated by PMSLIC's inability to deliver the lowest rates in town, so to speak, must surely appreciate how even more frustrating this has been to the physicians on our Board of Directors. The company has been run on a not-for-profit, break-even basis and is proud to boast the lowest operating cost ratio of any company doing business in Pennsylvania. You will recall that we got started at a rate level which was set 10 percent below that of Argonaut, whose portfolio PMSLIC inherited, in recognition of our determination to reduce our operating costs below those of Argonaut by at least that percentage, and we did just that! Thanks to our willingness to include earnings from our investments directly in our rate-making process, we have, in fact, kept rate increases over the past seven years to an absolute minimum. To be more precise, such increases since 1978 have averaged 6.1 percent annually, an amount which has barely matched the rate of inflation. Substantiation for the physicians' view that insurance costs are out of control comes from the more significant increases which have been levied by the Catastrophe Loss (CAT) Fund over the same period. In 1978 when PMSLIC got started, the CAT Fund was in its second consecutive year of providing $1 million excess coverage to all Pennsylvania licensed physicians *at no cost at all!* While that may have been a pleasant interlude for doctors and completely in accord with the provisions of Act 111 and its "pay as you go" concept, it was inevitable that the surcharges would begin to escalate thereafter, to the 1985 level of 70 percent. But I've strayed somewhat from your original question concerning the expectations of Pennsylvania physicians that PMSLIC's premiums would be lower than any other company's. This misrecollection is brought up to us quite often, but the facts show that in 1977 when the Society was seeking capital from its members to get PMSLIC started the only promise that it made as respects PMSLIC's rate level was that rates would be set "according to actual expenses" and would not be set in order "to pay dividends to stockholders." Those promises have been kept. No dividends have been paid and our current premiums, high as they may be, reflect precisely what our actuary tells us is represented by our "fully funded" liability. Actually, despite our best efforts to "break even," we suffered a bottom line operating loss for the past two calendar years, even taking into account earned

1975 The U.S. Viking spacecraft journeys to Mars. The Steelers are champs of professional football.

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investment income and that which we anticipate earning in the future on our loss reserves. From our independent actuary's point of view, our premiums are still not high enough to produce "break-even" results, given the present rate of new claims and suits, now averaging about 110 per month, and the increased costs which we see in defending and settling these claims.

Q. *Is this situation peculiar to PMSLIC and could it be a reflection of the company's unique relationship with the Pennsylvania Medical Society, which requires that you make coverage available to any Society member who requests it regardless of their individual loss experience?*

A. Oh yes, I think that our special relationship with the Society is part of the problem if you compare us with Medical Protective, for instance. That company is free to accept or reject any Pennsylvania physician as its underwriters see fit. More importantly, however, its management appears to have elected to structure its portfolio to keep physicians in high-risk specialties to a minimum, with a clear majority of its policyholders practicing low-risk medicine outside of the major urban practice locations. That underwriting posture has enabled Medical Protective to enjoy a very competitive rate level advantage. On the other hand, because PMSLIC was capitalized through the contributions of the Society's entire membership, we follow underwriting criteria which fairly reflect that constituency. That doesn't mean, however, that when a physician with multiple claims and suits alleging malpractice applies for coverage that we cannot take that unusual exposure into consideration in the premium process. While making a "profit" on our doctors is not a PMSLIC management goal, we obviously cannot knowingly afford to write business at a loss. Thus, whereas Medical Protective and our other major competitors use a "select or reject" underwriting mechanism, we have found a way, through the use of premium surcharges, to keep an open enrollment for PMS members who apply, equitably apportioning any extraordinary costs to those who generate same. We are satisfied that this underwriting approach has enabled us to maintain a well-balanced portfolio by specialty and location.

Q. *John, in the Hofflander/Nye report which you referenced earlier, the authors were critical of the manner in which most medical malpractice companies rate their business. The report recommended that instead of rating insured physicians by specialty class they be rated on the basis of individual loss experience. Aren't you saying that PMSLIC is already doing that?*

A. Yes, and we are pleased, of course, to learn that Professors Hofflander and Nye support our approach in their report. Obviously, you can't get away from class rating entirely. It is appropriate to track loss experience by specialty, and we do that. Additionally, PMSLIC tracks its loss experience by county—the only company to do that, I believe. We establish our rating territories by lumping together those counties, which, based on credible statistics, are producing similar loss ratio results. When you further refine that process through the application of surcharges on those individual physicians with multiple loss records, you are, in fact, utilizing the "experience" rating process recommended by Professors Hofflander and Nye. Again, to the best of my knowledge, though, we are the only company presently doing that.

PMSLIC is recognized as a company that will not be buffaloed into settling nuisance claims and it wins 80 percent of cases at the trial level, a tribute to its physician leaders.

Q. *John, I'd like to move away from the rating process for a moment and focus on claims and suits. Tell me about PMSLIC's claims-handling posture and whether or not this has changed over the years.*

A. Mary, one of the promises made by the Pennsylvania Medical Society to its membership when PMSLIC was capitalized was that physicians would make all claims-related decisions, and that claims without merit from a medical standpoint would be fought regardless of the cost. The Society knew that this posture would make PMSLIC significantly different from all other companies, which traditionally seek to settle any and all claims on the basis of economics rather than principle. I can state unequivocally that we have not faltered from that original goal since the company's inception. We have assembled an experienced claims staff, second to none, which continues to function at the explicit direction of our Claims Committee, composed exclusively of physicians. The staff implements the committee's decisions as to whether cases should be settled or tried to a conclusion on the basis of their medical merits. As a result of this posture, PMSLIC has established a reputation in the eyes of the plaintiffs' bar as a company which is not going to be buffaloed into settling "nuisance" claims just to get out from under them. Furthermore, we continue to win 80 percent of the suits which go to trial level, which I think is a testimonial to the good judgment of the physician members of our Board who decide, based on the medical facts of each case, whether or not we should settle or defend in court.

Q. *Talking about claims leads me into the subject of claims control or risk management. How effective is the emphasis on risk management in preventing the kinds of medical maloccurrences out of which claims or suits alleging malpractice occur?*

A. That's not an easy question to answer because trying to measure accurately the impact of risk management and loss prevention efforts is almost an impossible task. The whole purpose behind risk management is to educate and re-educate doctors continually on what medical activity or omission tends to produce results out of which malpractice claims occur. If one is successful in these efforts, it is reasonable to assume that whatever claims experience one is seeing would be even more severe absent such efforts. However, there is no absolute way that the impact can be measured and correlated directly with a company's loss results. Operating on the theory that no physician knowingly or deliberately invites the circumstances which result in patient injury, we have developed a continuous and varied risk management and loss prevention program which regularly alerts all members of the Pennsylvania Medical Society, not just our own policyholders, of those medical acts or omissions which have led to claims or suits and which should, therefore, be avoided or handled differently. With litigation against physicians at an all-time high, we feel very strongly that our loss pre-

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vention activities are accepted positively by all practicing physicians and that they are producing beneficial results, even though these can't be specifically pinpointed.

Q. *Do all companies offer similar risk management programs to their insureds in Pennsylvania?*

A. Unfortunately, no. While Act 111 requires that all companies writing medical malpractice insurance in Pennsylvania implement and offer a program of risk management and education acceptable to the Insurance Department, we have reason to believe that not all are meeting this obligation and that none of our competitors do nearly as much as PMSLIC to reach the individual practicing physician. An ongoing, professionally directed risk management program is an expensive undertaking and, here again, for those companies without PMSLIC's direct connection and commitment to physicians, the opportunity to enjoy short-term savings in operating costs by ignoring this important activity is hard to resist.

Q. *But if this kind of activity is required under Act 111, how do some companies get away with noncompliance?*

A. Mary, I'm in no position to answer that question, but I can suggest an easy way that the requirement be enforced. Every time a company makes a rate filing with the Pennsylvania Insurance Department, it should be required in that filing to indicate how much of its operating budget currently is being spent on risk management/loss prevention activities, what those activities consist of, and the estimated number of physicians which they serve. PMSLIC certainly would have no trouble complying with that requirement and would welcome any comparison between our absolute commitment in this field and the lack of such effort on the part of certain of our competitors whose advertised programs appear to be little more than figments of their imaginations!

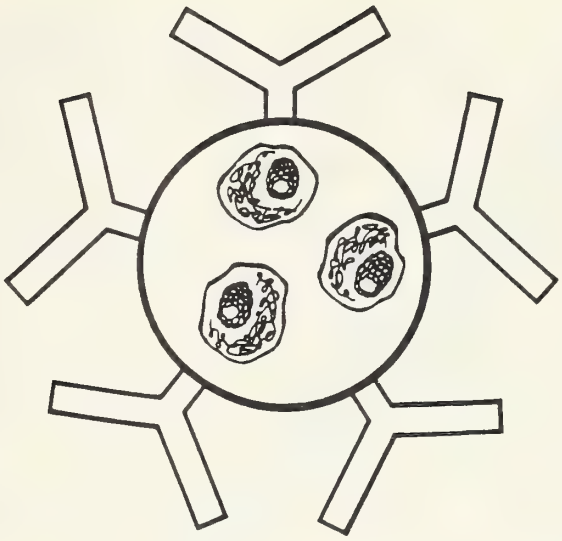
Q. *John, I have an idea that this session could go on indefinitely but the clock tells me we should bring this to a close. I have two more questions. First, what makes PMSLIC the preferred coverage for Pennsylvania physicians even though in today's market some companies are aggressively soliciting doctors at premiums below those of PMSLIC?*

A. Mary, no question is asked more often and is more difficult to answer! With the cost of primary and CAT Fund coverage at an all-time high, every physician is cost conscious. In that regard PMSLIC is committed to keeping its premiums at the lowest prudent level possible without putting its financial future as a company at risk. A majority of the physician members of the PMSLIC Board are also its policyholders, so when they vote to implement necessary premium increases, they are voting to increase their own costs. Neither the PMS, as PMSLIC's major shareholder, nor any member of the Board profits when those kinds of decisions are made. All we hope to do is break even; the rates set by our Board are aimed at doing that. We currently have approximately 6,000 policyholders, more than 50 percent of whom have been with us since the company's inception. The company is run by physicians, with a physician's point of view reflected in all of our activities. We're not just in the business of providing insurance. We have funded and committed substantial staff expertise to the Society's efforts on behalf of legislative reform of the malpractice compensation system. Physicians make all of the important company policy decisions. Every claim at PMSLIC is reviewed by physicians. Our all physician Underwriting Committee, which met 13 times during 1984, has interviewed scores of policyholders who have experienced multiple claims to see what practice improvements will make them more loss free and to determine their continued acceptability to our company. The Risk Management Department has set the standard for educational initiatives to assist our policyholders, and even those members of the Pennsylvania Medical Society who are not with PMSLIC, in practicing safer, claim-free medicine. This year we formed the PMSLIC Consumer Discount Company in order to permit our policyholders the option of paying the CAT Fund surcharge on a quarterly basis. Thirty percent of our insureds opted for this method of alleviating the cash flow problem imposed by the statutory requirement that CAT Fund surcharges be paid in a lump sum. Thousands of our past and current policyholders have enjoyed premium discounts as a result of PMSLIC's willingness to tailor its coverage to the particular needs of as many PMS member insureds as possible—those just entering practice and those whose practices are winding down. It is difficult to put a price on these important intangible PMSLIC benefits. PMSLIC must survive as a company or Pennsylvania physicians will once again be at the mercy of the commercial insurance industry for their malpractice insurance needs, instead of being in the hands of a physician-directed company which is working toward changing the present hostile legal environment in which they all must practice. Under these circumstances, "solidarity" in and of itself is a legitimate and appropriate reason for choosing and maintaining coverage with PMSLIC, even when cut rates with a company new to the marketplace appear to offer some temporary insurance cost relief.

> Every time a company makes a rate filing, it should be required to indicate how much of its budget is spent on risk management.

Q. *John, the final question. When can Pennsylvania physicians expect to see the leveling off of malpractice insurance costs?*

A. Mary, in my opinion the leveling off process will not occur until the Pennsylvania legislature acts to moderate the present malpractice compensation system along the lines proposed by the Pennsylvania Medical Society. Until that happens, malpractice insurance companies will continue to pay out more than they are taking in and given that scenario, additional rate level increases are inevitable on the part of all companies. The same can be anticipated for the Catastrophe Loss Fund. The sad truth is that even though malpractice insurance costs in Pennsylvania are at an all-time high, the loss experience being registered by all companies argues rather convincingly that such premiums are still not sufficient to fund the current level of payouts and those which we can reasonably forecast for the future. Legislative reform must occur but that won't happen until every physician supports with time and money the Society's efforts to convince the public that confiscatory premiums are reflected in ever-increasing fees and, therefore, reform is in the public's best interests.



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New laws strengthen licensing boards

Robert L. Lamb

The Pennsylvania General Assembly adopted legislation, signed by Governor Dick Thornburgh May 2, strengthening the disciplinary powers of the State Board of Medical Education and Licensure. The new laws, which had the support of the Pennsylvania Medical Society, became effective immediately on signing.

Act 7 of 1985 (Senate Bill 338) provides for automatic suspension of a medical license upon conviction of a felony under the "Controlled Substance Act." It also prevents the granting of a Pennsylvania medical license to any one convicted of a felony under the controlled substance, drug, device, and cosmetic laws anywhere in the country. A conviction includes a "judgment," an admission of guilt, or a plea of *nolo contendere*. The automatic suspension remains in effect during the appeals process.

Five companion bills add the same amendments to the licensing laws of osteopathic physicians and dentists, pharmacists, nurses, and other health professionals.

Act 6 of 1985 (Senate Bill 83) gives the medical board the power to suspend a doctor's license for up to 180 days without a hearing if the physician is found to be an immediate and clear danger to public health or safety.

Within thirty days of announcing the temporary suspension, the Board must hold a preliminary hearing. The licensee may be present at the hearing and be represented by counsel, cross-examine witnesses, inspect physical evidence, call witnesses, offer evidence and testimony, and make a record of the proceedings. Formal action, in the form of exoneration or an extended suspension or revocation of the license, would be required within six months.

Also, the measure specifies that a license could be refused, suspended or revoked for fraudulent statements and practices in obtaining a license, either as a conspirator or as an individual, or for fraud in obtaining admission to medical school.

The State Board of Medical Education and Licensure has been criticized because it could not lift the licenses even of physicians convicted of felonies while their convictions were appealed through the courts. Act 6 of 1985 permits summary suspension in these cases.

At this writing, Senate Bill 81, also supported by PMS, appears near passage. It requires "health care facilities and hospitals" to report "the termination or curtailment of the employment, association, or professional privileges of a physician . . . for alleged malpractice or misconduct;" or "the resignation or withdrawal of association or of privileges . . . to avoid the imposition of disciplinary measures or the receipt of information which indicates that any physician has been convicted of a felony."

The required reports would be confidential "except upon formal written request by a duly authorized public agency or pursuant to a judicial subpoena issued in a pending action or proceeding." Persons making the reports "in good faith and without malice" would have "immunity from any liability, civil or criminal, for having made such a report."

To make physician leaders aware of disciplinary actions taken by the State Board of Medical Education and Licensure, the PMS Council on Education and Science distributes a newsletter listing all the names of physicians disciplined by the Board and the nature of the action taken.

The legislative spotlight will remain on the State Board of Medical Education and Licensure and all other health boards in 1985 since the various laws which established these boards all are scheduled for sunset review to determine whether or not the boards should be continued.

The writer is director of communications for the Pennsylvania Medical Society.

Dr. Fink elected APA vice president

Paul J. Fink, MD, has been elected vice president of the American Psychiatric Association (APA), which represents more than 30,000 psychiatrists nationwide. Dr. Fink is chairman of the department of psychiatry at the northern division of Albert Einstein Medical Center, Philadelphia, and medical director of Einstein's city psychiatric center. He is professor and deputy chairman of the department of psychiatry at Temple University School of Medicine.

Dr. Fink's election culminates a history of service to the association. He is chairman of the APA's Joint Commission of Public Affairs, and a member of the Joint Reference Committee, which deals with many of the association's business matters. Also, he is a member of the task force on prospective payment and the ad hoc committee to the APA office of economic affairs. In 1982, he received the Seymour D. Vestermark Award in recognition of his outstanding contributions to undergraduate and postgraduate education.

Dr. Fink is secretary for the National Advisory Mental Health Council and is former chairman of the Pennsylvania

Medical Society's Council on Governmental Relations. He is past president of the American Association of Chairmen of Departments of Psychiatry, the Association for Academic Psychiatry, and the Philadelphia Psychiatric Society.

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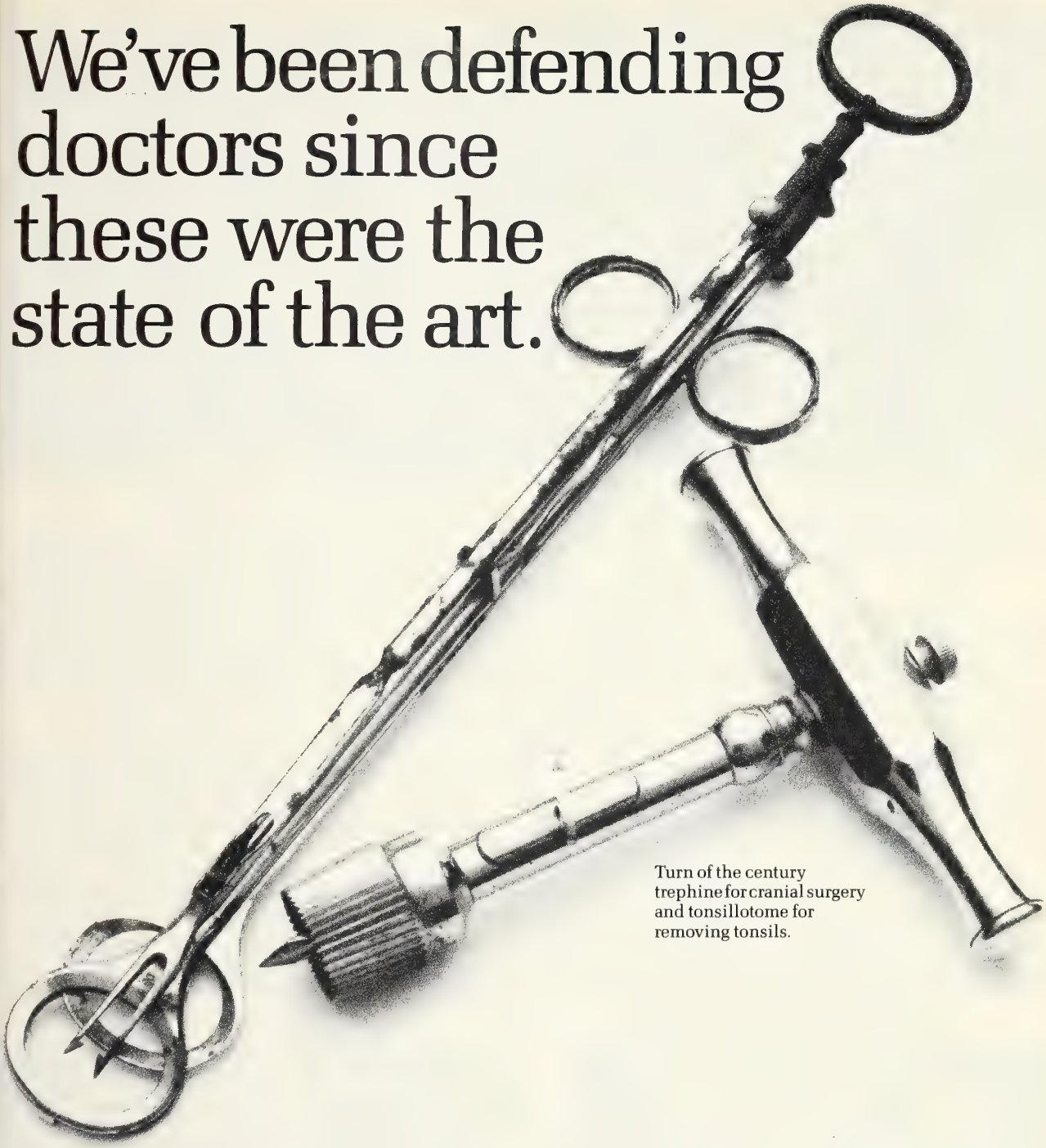

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physicians in the news

Edward J. Stemmler, MD, has been recognized by the American College of Physicians (ACP) for outstanding contributions to internal medicine as an educator, administrator, and expert investigator of pulmonary medicine. Dr. Stemmler was honored with ACP Mastership at the organization's scientific meeting in Washington, DC. For 25 years Dr. Stemmler has held various posts at the University of Pennsylvania, including dean of the school of medicine. He is immediate past chairman of the Council of Deans of the Association of American Medical Colleges, and he has served as treasurer and regent of the American College of Physicians. Of the 60,000 college members, fewer than 200 are honored with the rank of ACP Master.

Myron Yanoff, MD, director of Scheie Eye Institute, gave the eighth Francis Heed Adler Lecture at the annual meeting of the University of Pennsylvania Alumni Ophthalmological Association in April. Dr. Yanoff, who also serves as chairman of the departments of ophthalmology at University of Pennsylvania and Presbyterian-University of Pennsylvania Medical Center, spoke on magnetic resonance imaging.

Herman Beerman, MD, was honored recently by the College of Physicians of Philadelphia for his distinguished record of 50 years of service to the college. Dr. Beerman is emeritus professor of dermatology at the University of Pennsylvania School of Medicine, and a member of the dermatology department at the Hospital of the University of Pennsylvania. He has served as president of the American Society of Dermatopathology, the Society of Investigative Dermatology, and the Philadelphia Dermatological Society.

Donald Haselhuhn, MD, Camp Hill, received one of four national awards given by the National Multiple Sclerosis Society each year to people who exemplify what a patient can achieve in spite of disease. Dr. Haselhuhn, who has been afflicted with multiple sclerosis, is director of the school of anesthesiology at Harrisburg Hospital, and a member of the board of directors of the local multiple sclerosis chapter.

David B. Soll, MD, Philadelphia, has been elected president of the Philadelphia Society of Facial Plastic Surgeons. The society is made up of otolaryngologists, ophthalmologists, dermatologists, and plastic surgeons who are involved in cosmetic and reconstructive facial surgery. Dr. Soll is professor and chairman of the department of ophthalmology at Hahnemann University, and he directs ophthalmology services at Frankford and Rolling Hill Hospitals and the Philadelphia Geriatric Center.

Stephen A. Feig, MD, Philadelphia, has been appointed vice chairman of the department of radiology at Jefferson Medical College. An expert on mammography and breast cancer screening, Dr. Feig is the editor of the book, *Breast Carcinoma: Current Diagnosis and Treatment,* and has contributed over 100 papers to the medical literature.

Kenneth M. Logan, MD, Pittsburgh, has been selected one of eighteen industrial physicians and occupational specialists who will attend a three week seminar directed by the Republic of China and the Chinese Medical Society. While in China, the group will visit Hong Kong, Shanghai, Peking, Anshan, and Huainan.

Lancaster General Hospital presented **Irene B. Davis, MD,** with a plaque commemorating her 59 years of service to medicine. Dr. Davis, an obstetrician and gynecologist, delivered over 6,000 babies at Lancaster General Hospital during her medical career.

Harold S. Pond, MD, is the second recipient of the Gold Medal Award for outstanding contributions toward the advancement of community health, given by Pocono Hospital. The first award was given to **Claus Jordan, MD,** the first Board certified specialist to practice at Pocono Hospital. Dr. Jordan, a graduate of the University of Pennsylvania School of Medicine, urged other students at the medical school to start practice in Monroe County.

At the Delaware County Medical Society's annual dinner dance, Society President D. Ernest Witt, MD, presented an award for 50 years of medical service to Frances M. Triboletti, MD. Also at that event, Howard A. Richter, MD, (extreme right) gave the president's gavel to the new county society president, Samuel D. Allen, MD. Dr. Richter served as president in 1984-85.

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But not when it comes to chronic schizophrenia. Victims of this devastating disorder have special needs requiring special attention. What works for one patient doesn't always work for another.

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Each program places a strong emphasis on *intensive, individualized* treatment of the patient. That personalized attention begins with a careful physical and psychological evaluation which is continually updated throughout the patient's stay. Based on these assessments, patients receive treatment tailored to their specific needs. For some, the milieu therapy approach based on psychodynamic principles is best. For others, the social learning theory approach is more effective.

Patients in both programs have their own personal psychotherapists, and are placed in a structured, consistent environment that is designed to reduce their internal chaos. Medications are not used as substitutes for social or psychological needs, but are parts of a comprehensive treatment program.

Our staff of nurses, mental health workers, activity therapists, social workers, psychologists and psychiatrists work together with the patient and the patient's family to create a more balanced, integrated person.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Medical staffs need counsel for bylaws revision

eif C. Beck, LLB, CPBC

William L. Trombetta, JD, PhD

Geoffrey T. Anders, CPA, JD, CPBC

We recently participated in a three-day National Health Lawyers' ssociation seminar, "Medical Staff Le-al Issues." Over 200 attorneys from cross the country attended the pro-ram, a fact that indicates medical staff natters are indeed an area of legal con-ern.

A variety of speakers showed philo-ophical, and quite clearly financial, dis-inctions between two views. Hospital fficials and their attorneys had one iew, marked by a basic position that ıospitals are the lead players in health are. Under this position, physicians nd their medical staffs should be nei-her strong, independent organizations nor separately advised as to their con-cerns. The contrary view, held by physi-cians and their attorneys, was that medical staffs are of independent im-portance and, even though working co-operatively with their hospitals, must have their own conscientious legal and business advice.

This split of attitudes, which we expect will affect many Pennsylvania physicians' dealings with their hospitals, is clearly exhibited in the subject of medical staff bylaws. Since the revised JCAH Standards require virtually every hospital's medical staff bylaws to be substantially revised, the issue of legal and business advice will definitely arise.

"Gut issues" in bylaws

While 90 percent or more of medical staff bylaws are not controversial, susceptible to "boilerplate" provisions, there are some extremely important areas of concern both to physicians and hospitals. Model bylaws drafted by conflicting associations (most notably in California by its state medical association and its state hospital association) disagree in at least the following four areas:

1. *Power of the governing body*—Does the medical staff have its own authority or does the hospital's governing body have final control, often by veto or approval power?

2. *Economic matters*—Are the hospital's economic circumstances a direct, organizational concern of the medical staff, or is the staff separate from (though obviously interested in) hospital economics?

3. *Extent of power*—Does the hospital or the medical staff have control and responsibility over doctors employed by the hospital? How much right should the hospital have in monitoring its physicians' performances and in calling for disciplinary hearings or other actions?

4. *Due process*—How extensive should be a physician staff member's right of due process, as to admission, privileges, reappointment, suspension,

The authors are principal attorneys and consultants affiliated with the Health Care Group, Bala Cynwyd.

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or termination? How shall the hospital's desire for a prompt, though legally sufficient, process be balanced with physicians' traditional concern for its individual members' rights?

While other areas of difference also will exist, these four examples show that basic philosophy can make bylaw revision extremely difficult. Both the medical staff and the hospital should want to complete the revision—get it out of the way—so they can move on to more important matters, but coping with a written document can too easily siphon away their attention.

The attorneys at our seminar seemed to recognize this point. Bylaws raise subtle issues of basic relationships that may be better handled informally than in writing. Perhaps medical staff organizations and hospital leaders coexist by unwritten understandings of each other's circumstances; attempting to state specifically the arrangements might upset a relationship that has avoided confrontation. Thus, hospital advisors tend to fall back on their "gut issue" that hospitals are prime players and that medical staffs are mere committees thereunder.

Physicians' advisors, however, point out important concerns in this rapidly changing health care climate. If medical staffs do have their own legitimate interests, as is implicit in the AMA's position and in current economics, they must assure themselves of a proper structure within the bylaws. In effect, if these matters will be written at all, doctors must assure that the writings are fair to their interests.

The players

We were particularly interested in one speaker's approach to bylaw matters. As a Pennsylvanian active in many staff bylaw revisions, his approach should be considered by physicians practicing in this state. He is Nathan Hershey, a professor of health law at the University of Pittsburgh and also counsel to both a Pittsburgh and a Philadelphia law firm.

In this speaker's approach, medical staff bylaw revision should involve a supposedly neutral, otherwise unrelated expert to serve as the "draftsman." His or her duties should be to point out the essential, important questions before the two sides and to put their agreed decisions into a final writing.

In concept, the draftsman apparently would be impartial and thus of equal trust to the medical staff as to the hospital. However, since this person is presumably selected and paid by the hospital, we can hardly consider the draftsman to be truly independent. We therefore advise that a medical staff cannot accept such a draftsman as a disinterested person to whom it can entrust its confidence.

The other players in Mr. Hershey's game plan include: (1) the hospital's chief executive, (2) the medical staff's bylaws committee, (3) key leaders of the medical staff, (4) the hospital's attorney and (5) the hospital board's leaders. This represents a stacked deck against the medical staff, most notably because an attorney or other advisor to it is omitted.

On the hospital's side of the project are a variety of experienced, business-trained individuals. The hospital's chief executive and its board leaders are typically effective businessmen, while its attorney is presumably skilled in representing clients in business relationships. On the medical staff, there would be only physicians who comprise the bylaws committee and staff officer positions. And the other player, presumably the neutral party who might seek the medical staff's confidence, is the above-described, hospital-selected and compensated "draftsman."

In our experience, most physicians are neither trained nor experienced in business matters. They certainly have little or no background in dealing with complex matters of bylaws document language and its subtle implications of organizational and legal importance. Furthermore, we rarely find that a committee can effectively develop rational, consistent responses to such matters without a single individual's coordination and leadership.

The prescribed format for bylaws revision thus presents a "stacked deck" for a hospital. It pits business people against physicians, and it gives these businessmen the assistance of their lawyer and their selected "draftsman" while allowing no trained advisors for the doctors. This is not a good environment within which to resolve important questions which may seriously affect the physicians' individual and collective interests.

Medical staff advisor

The obvious solution is for a medical staff to retain its own attorney or other business advisor. The purpose of this hiring would be not to complicate the revision by adversary rhetoric, but rather to assure that the responsible physicians understand the implications of the various matters raised in the process. Its attorney/advisor should recognize that the client wants the bylaws revision to be accomplished without damage to either party or to the relations between them—not that the client should "win" on each issue raised in the process.

The staff's advisor typically will be an attorney well versed in health care matters. However, in some cases a business consultant with experience in medical matters is a satisfactory alternative choice. The primary point is simply that the physicians' side of the table must have some level of expertise and experience comparable to the hospital's side.

Medical staffs unfortunately encounter one problem not bedeviling the hospital. Hiring an attorney or other advisor will be fairly expensive and the amount of fee involved cannot be predicted in advance. While the attorney/advisor typically will be paid on the basis of hours expended, there is no way to predict whether the process will be quick and easy or tortuously time-consuming. Due to a medical staff's multiple committee structure, plus the natural inability of busy physicians to give undivided attention to the bylaws project, the unpredictability will often be the staff's own fault.

Medical staff budgets usually are limited; the process for raising additional funds by special assessment can be difficult and uncertain. Thus the staff's leaders should consider in their advance budgeting the possibility of considerable legal/advisory fee expense. Staffs simply can no longer function on a shoestring when such vital issues may present themselves and when outside assistance is essential to their long-term benefit.

Conclusion

Since each hospital is encountering or will encounter medical staff bylaws revision to meet new JCAH Standards, difficult issues may arise. These issues may affect physicians significantly, but the doctors are apparently expected to deal with them without legal or other advisory assistance. This presents a "stacked deck" against the staff, but it will have to raise sufficient funds to afford good counsel. The times are becoming complex and competitive enough that a medical staff can hardly avoid the expense. □

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5 mg 10 mg 20 mg 30 mg 40 mg — Oral "Swallow" Tablets

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See following page for brief summary of prescribing information.

SORBITRATE
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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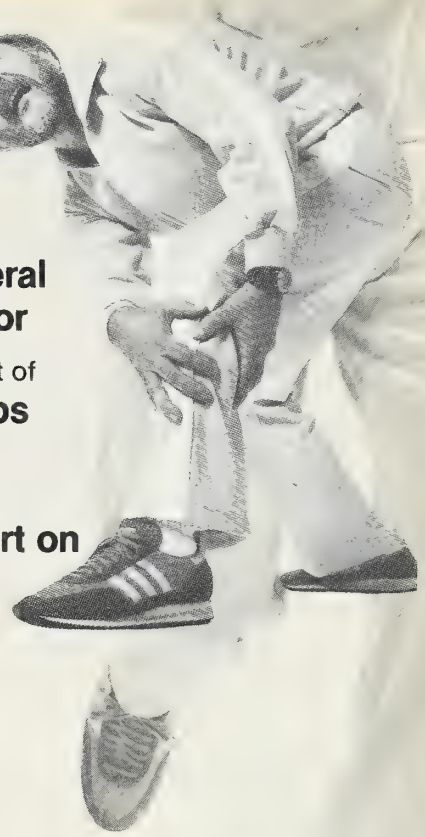

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AVAILABLE: Bottles of 100, 500.

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obituaries

• *Denotes PMS membership at death.*

• **Stephen Andolina**, Connellsville; Loyola University of Chicago Stritch School of Medicine, 1936; age 72, died April 12, 1985. Dr. Andolina was a general surgeon on the staff of Connellsville State General Hospital.

• **Walter I. Buchert**, Danville; University of Pennsylvania School of Medicine, 1933; age 77, died May 5, 1985. Dr. Buchert, who organized Geisinger Medical Center's department of urology in 1937, was medical director of the center from 1958 to 1972. He also was a founder of the center's Institute of Medical Education and Research.

• **Joseph P. Choby**, Doylestown; Case Western Reserve University School of Medicine, 1933; age 81, died May 8, 1985. Dr. Choby was a surgeon.

• **Bruce G. Farrell**, Erie; State University of New York Upstate Medical Center College of Medicine, 1972; age 39, died April 17, 1985. Dr. Farrell was a thoracic surgeon.

• **Harry P. Goodman**, Secane; University of Pennsylvania School of Medicine, 1925; age 84, died February 14, 1985. Dr. Goodman ws a psychiatrist.

• **Morton Gutnick**, Philadelphia; Hahnemann University School of Medicine, 1942; age 71, died March 24, 1985. Dr. Gutnick specialized in obstetrics and gynecology.

• **John J. Huebner Jr.**, Johnstown; University of Pittsburgh School of Medicine, 1933; age 75, died March 26, 1985. Dr. Huebner, a general practitioner, was past president of the Cambria County Medical Society.

• **Orville Carrier King**, Philadelphia; Jefferson Medical College of Thomas Jefferson University, 1927; age 84, died March 26, 1985. Dr. King was professor of clinical surgery at the University of Pennsylvania, and former director of the department of surgery at Pennsylvania Hospital.

• **Gerald H. Nadeau**, Riegelsville, University of Minnesota Medical School, 1945; age 64, died April 13, 1985. Dr. Nadeau was a family physician in Riegelsville since 1948.

• **James P. Paul**, McClellan Heights; University of Pennsylvania School of Medicine, 1922; age 90, died March 28, 1985. Dr. Paul practiced medicine in York for over 50 years.

• **Linwood John Pearson**, Fleetwood; University of Pennsylvania School of Medicine, 1948; age 60, died April 23, 1985. Dr. Pearson was the southeast district medical director for the Pennsylvania department of health.

• **Joseph William Piekarski**, Wilkes-Barre; Temple University School of Medicine, 1929; age 91, died March 29, 1985. Dr. Piekarski was a psychiatrist.

• **Ervin E. Rodriguez**, North Port, Florida; Temple University School of Medicine, 1943; age 67, died May 3, 1985. Dr. Rodriguez practiced orthopedic surgery in Lewistown before his retirement in 1983.

• **Henry C. Schneider Sr.**, Delray Beach, Florida; Temple University School of Medicine, 1936; age 77, died March 22, 1985. Dr. Schneider was a former clinical associate professor of surgery at Temple University.

• **Katherine L. Shaw**, Glenshaw; New York University School of Medicine, 1925; age 94, died April 13, 1985. Dr. Shaw, one of the first woman physicians in Allegheny County, was a forensic pathologist.

• **Joseph C. Staley**, Uniontown; University of Pittsburgh School of Medicine, 1931; age 78, died April 15, 1985. Dr. Staley was an internist.

• **Helen Tananis Szypulski**, Fayetteville; Temple University School of Medicine, 1938; age 72, died April 14, 1985. Dr. Szypulski was a general surgeon.

• **Edward Hoge Vick**, Haverford; Jefferson Medical College of Thomas Jefferson University, 1941; age 68, died April 18, 1985. Dr. Vick served as chief of pediatrics at Lankenau Hospital from 1960 to 1982, and was clinical professor of pediatrics at Jefferson Medical College.

• **George A. Zuck**, Pittsburgh; University of Pittsburgh School of Medicine, 1924; age 85, died May 8, 1985. Dr. Zuck specialized in internal medicine.

Charles Catanzaro, Moorestown, New Jersey; Jefferson Medical College of Thomas Jefferson University, 1946; age 65, died April 1, 1985. Dr. Catanzaro was former attending pathologist at Bucks County Hospital.

Carl W. Gatter, Mt. Lebanon; University of Pittsburgh School of Medicine, 1920; age 89, died April 11, 1985. Dr. Gatter was a psychiatrist.

Richard M. Klussman, York; University of Pennsylvania School of Medicine; age 87, died May 9, 1985. Dr. Klussman practiced for 61 years as an obstetrician and gynecologist.

Wallace William Steehler, Erie; Kirksville College of Osteopathic Medicine; age 73, died April 3, 1985. Dr. Steehler was a physician at Metro Health Center, Erie.

MEMBERSHIP DIRECTORY

1985-86

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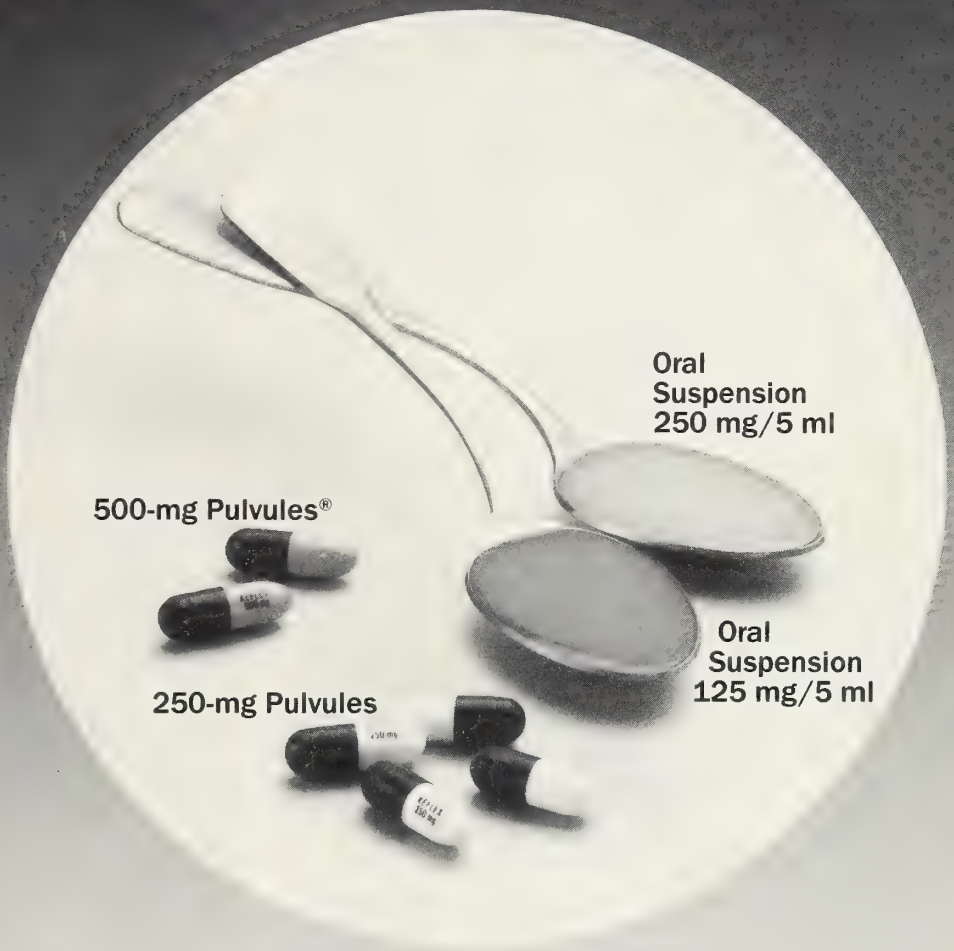

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in my opinion

Erosion of confidence

Leo H. Criep, MD

Medicine has made tremendous technical advances in recent years. At the same time it has been distressing to note that despite such progress, public confidence in the medical profession has undergone considerable erosion. While recognizing and appreciating professional competence, the public often regards physicians as unfeeling and lacking in compassion and humility. Such allegations are by no means universal, but they occur with sufficient frequency to merit inquiry.

The indictment

To begin with there is the waiting room problem; I refer to it as the "waiting room blues." A call for an appointment too often is answered in a cold impersonal manner. While the patient is expected to report promptly, the physician does not have the corresponding obligation. The sick must wait in crowded waiting rooms for seemingly endless hours before being shuttled into an examining room for a lonely vigil. When finally in *The Presence* to relate complaints and be examined the patient may well be exhausted. While an initial brief visit can offer valuable diagnostic information, the experience can lack warmth and appreciation of the patient as an anxious, suffering human being.

When numerous sophisticated and costly procedures are ordered and days later the patient appears for his final verdict, the entire experience often emerges as an impersonal, insensitive, and dehumanizing episode. While an attempt should be made, especially in the case of serious illness, to understand the patient's psychosocial and socioeconomic situation, often it is not. A meeting free of compassion, reassurance, and encouragement fails to alleviate panic, and there may be an additional cost. Lack of understanding and adequate communication can result in low patient compliance or other obstacles to successful treatment.

Cost of medical care

Either out of curiosity or because of need for avoiding the increasing risk of malpractice lawsuits, long lists of costly procedures are ordered. To quote the inimitable Art Buchwald, "One of the reasons medical costs are soaring is defensive medicine, because for every doctor practicing medicine, there are now two lawyers waiting to sue him for malpractice." Is it justifiable for a physician to build excessive overhead into fees? The need to address ways to avoid hospitalization for marginal procedures that may be done using outpatient facilities seems long overdue.

The hospital

Hospitalization can be a new and frightening experience, often aggravated by careless and unfeeling attitudes of hospital personnel. It is frustrating to patient and family to direct complaints to the doctor about such experiences little realizing that the busy attending physician does not have the time or even the authority to correct them.

The prescription

The question then arises, what can be done to correct these and other factors responsible for the erosion of public confidence in those charged with medical care? Critical self-evaluation by the profession appears mandatory if for no other reason than to avoid growing governmental and commercial control of medical care. Exposure to teaching or guidance in medical psychology, social and behavioral science should be provided. For many years in the past I conducted weekly conferences on medical ethics and humanism at the University of Pittsburgh School of Medicine. It is good to note that some other medical schools are now showing an active interest in such programs. It would be a step forward if similar conferences could be considered a part of training for hospital medical house staff.

In order to stimulate such interest we have established an annual award to those outgoing medical residents who during their periods of service have shown interest in their patients as suffering humans. However, education of the medical student, the house staff, and the attending physician alone is not enough. The physician should see to the extension of such education to nurses, hospital staff, and office medical aides and secretaries.

There exists a desperate need for close interaction between the physician and those in his care. Taking care of a patient involves *caring about him.* Sir William Osler said, "It is as important for the physician to know what patient a disease has as it is to know what disease a patient has."

Such an appreciation only can be brought about by increased familiarity with the sick, their life situations, and their anxieties. This especially is true when dealing with the elderly, for whom illness poses a special threat of insecurity, incapacity, or death. Perhaps only a physician or a member of his family who has had a bout with illness can appreciate its stress and strain.

The cost of medical care may be reduced further by controlling the prescription of expensive drugs and by bypassing unneeded costly procedures. Since physicians traditionally have been willing to reduce fees as circumstances demand, frank initial discussions with the patient should not be shunned. Quality medical care is a growing concern as attested to by the number of public organizations involved in stimulating interest in the role of humanistic medicine. It is gratifying to note that among other organizations the American Board of Internal Medicine is "committed to requiring high standards of humanistic behavior in the lives of every candidate for examination."

The license to practice medicine carries with it a moral obligation to society. A proper discharge of such dedicated obligation will go a long way toward narrowing the gap in the present eroding physician—patient relationship.

The author is Distinguished Professor of Medicine Emeritus at University of Pittsburgh.

Hail and farewell from an originator

George A. Rowland, MD

Every year, according to the bylaws of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC), it is the function of the PMS Board of Trustees to name the company's directors. Directors are elected for one year terms.

The purpose of this arrangement is to retain full control of the company in the hands of PMS, which owns all of the stock. Under this plan, the full board could be changed on any anniversary date. As might be expected, however, the tendency has been to reappoint those otherwise capable.

It came as a shock to me then when I found myself as one of only two directors who were not reappointed for the year 1985.

After looking at the situation more objectively I have softened my reaction. The arrangement for selecting directors is one that I favored and fought for. I supported the one year term and I still favor the PMS Board, my old team, as the ones to have the final say on who should run the Pennsylvania Medical Society Liability Insurance Company.

I also supported the rule for compulsory retirement at age 70, and as I near that age I have been aware of a gathering cloud ahead of me. This quick, kind cut takes away that sense of impending doom, and I am grateful for that. Although I never planned on being an object lesson myself, I have felt that younger voices from the mainstream of medical practice have been needed in PMSLIC.

There are others who did as much, or more, ground work to get PMSLIC started as I did, but I will always treasure the fact that it was I, when everything was at a standstill, who determined that the time was right, pulled the switch, and set it all in operation. My relation to the company will always be somewhat paternal and, like a good father, I will watch my child, now maturing, go on its own way.

I am very proud of the PMSLIC Board. The chairman and the president were picked with care and they have led us well. The clean record of a highly respected company has resulted not only from good direction but also from a board where every member has meticulously observed every move and commented freely on most.

The staff is outstanding. They have set the operation moving smoothly and efficiently, but also compassionately. Computers serve us, but our policy holders stay because they know that PMSLIC cares. The personal equation is all important here.

Today PMSLIC stands alone as the only seriously functioning peer review organization in Pennsylvania. This may be, in the last analysis, the greatest benefit that PMSLIC has given Pennsylvania physicians. People used to say, all too truly, that doctors did not police their own house. Because of PMSLIC and others like it in other states, this is no longer true. We do what the for-profit companies never even tried. There is beginning to be a risk management-peer review system that really works.

As long as I can, I will watch the company's course. The skies ahead are not bright and storms are certain, but we have launched a seaworthy ship with a top notch crew. I consider it to have been a rare privilege to have had a hand in its first trials.

Dr. Rowland was chairman of the PMS Board of Trustees when PMSLIC was incorporated. He also was a director of the company for more than seven years, from its inception until this spring. Dr. Rowland is a family physician in Millville.

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special feature

Public principles, private lives

Naomi Bluestone, MD

Public health professionals like me have always been considered moralistic, preachy, and removed from the realities of private practice (by doctors) and private life (by civilians). Perceived as authoritarians who tell other people what is good for them, and policemen of all the pleasurable things the public is no longer allowed to do, they epitomize the discomfort of being public prophet, doomsayer, and badman. But what of private practitioners (I am now one), who *also* know with unwelcome clarity what is good for the body and what is not. Is their responsibility limited to their own health or the health of their patients? Or are they also accountable in some way for the physical well being of their spouses, families, and friends back in suburbia?

For example, let's examine the prototypic health issues of smoking and overeating. My question is: Do health care professionals practice what they preach in their private lives? If no, why not? I am not referring to the ten thousand doctors who have quit smoking, or the far fewer physicians who have put themselves on diets and kept the weight off. I am talking about folks who believe that smoking and overeating are bad habits, and are willing to put those principles on the line not just with their bodies, but in their own homes. It is one thing for a professional person to make a personal choice to reform his ways and give up the weed or the chocolate. It is quite another thing for him to do battle with spouse and kids about keeping the stuff out of the house and setting a good example with a healthy familial life style.

What does it take for a doctor to ask his visitors not to smoke in his house? Principles? Boorishness? Saintliness? Assertiveness? Rudeness? All of the above? None of the above? Will a doctor limit the foods he serves his guests, or continue to stuff them up the gazoo, like an Italian mama descending with a huge bowl of hot pasta, saying "Eat, eat!" What happens when "health professional" and "gracious host" merge at the front door?

My freshly renewed interest in the possible dichotomies between public principles and private life was sparked by a remembrance from the past. I recently saw the obituary in The New York Times of Dr. William Haddon, Jr., who built a career as a public health physician championing safety in automobiles, and to whom this nation owes much gratitude for the reduction of highway fatalities. Dr. Haddon interviewed me for my first job in public health in 1964. He drove me all around Washington in a little Saab with the first shoulder harness I'd ever seen. This man drove like a maniac, weaving his way in and out of traffic while my teeth chattered and my knuckles bleached white on the door grip. Since then, I have seen the greatest reformers espouse truly and deeply held beliefs, yet abandon them to social pressures at home. Are these people wimps in their own living rooms? Or do they ascribe to principles higher than the blind preservation of human life?

Taking a stand

Let me introduce you to two women who have taken rather forthright stands on these issues, Hedda Batwin and Hermine Plotnick. (Yes, these names are real and these women are my friends.)

When spouse and I realized that creeping corpulence was taking a toll in terms that were now more debilitating then simply cosmetic, we consulted Hedda, a nutritionist with a reputation for providing not only the latest in nutritional information, but culinary suggestions that helped ease the transition from diet sheet to palate. We rang her bell propelled more by desperation than by the hope that she knew something we didn't know.

Actually, she did. Formerly a chemist and a cooking teacher, she liberally punctuated her advice to us with examples from her own kitchen and proved a limitless source of ingenuity about applying the rules of fine food preparation within the confines of a low calorie, low salt diet from which we banished all seafood and porcine products.

We discovered that the higher powers of eating now permit the carbohydrates we always craved, having confirmed that they relieve depression. They have also cut back on protein, treating it as a condiment rather than the bedrock of long-range satiety we had been led to believe. These developments were fine with us. Jubilant that openly eating a slice of bagel was no longer an immoral act, we started to lose weight. Even better, we began to be relieved of the emotional tyranny of food. We ceased to ruminate about it, to build our schedules around access to it, and to experience the reactive depression that would follow our formerly frequent losses of impulse control.

There was no doubt that Hedda practiced what she preached in the privacy of her home. But what happened when conflicts arose between her standards and those of society? Our town is famous for gargantuan appetites and limitless culinary grandiosity. How did this woman, living a life of suburban temptation, entertain her sophisticated guests? Did she suspend belief in the moral degeneracy of cholesterol/triglyceride elevations and the rottenness of the simple sugars, when a Saturday night put her reputation as a hostess on the line?

"We had a great dinner for ten," she said, reading my thoughts. "It was a smash." Encouraged by our interest, Hedda outlined a string of gourmet dishes that made our mouths water. They had all been prepared according to the precepts of good eating. Her veggies had been steamed, her salmon poached, her sauces pared, her fats measured, and her chemicals banished. The complex carbohydrates were homebaked and still warm, while her beverages were stripped of little bubbles of caffeine, aniline colorings, and mouse-

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liver toxins. Suffused with virtue, yet aware that moderation makes all things possible, she indulged in ice-cream cake for dessert, served in limited portions that would satisfy the urge for sweets without ruining the towering edifice of health she had built on her dinner table.

We were in awe of her nerve, daring and skill. She giggled. "It was really fascinating to observe how the guests ate," she said clinically. She said that the slim ones were controlled and satisfied on limited portions. The fat ones looked around hungrily for seconds.

After sharing her recipes with us, Hedda stated her belief that Americans eat too much of the wrong things and that it isn't good for them. She said she didn't want them to do it in her home. She said she wanted to show them that there was a better way, that food could be healthful, nutritious, and delicious, and that it did not have to be consumed by the bale, like oats, to bring satisfaction to the belly and satiety to the "appestat." So why *not* cook them a dinner to set a good example and send them home without guilt? But wasn't she ever teased, we asked. Often. Did she reply? Certainly, and with good humor. And this night there had not been a peep out of any of her guests!

We reflected on her old-fashioned courage in defying social mores on the banquet floor. It reminded us of Hermine. Hermine's front door boasts a sign that says, WE RESPECTFULLY REQUEST THAT OUR GUESTS REFRAIN FROM SMOKING. She arrived at this ultimatum in step-wise fashion. First, she put cigarettes out for guests, as good hosts used to do. Then she only left ashtrays. Then she removed the ashtrays. Then she left pretty small signs on the coffee table asking people not to smoke. Then one day she said to herself, "It's time to be upfront." Has she gotten nasty responses? The closest has been the question, "Do you still have that sign on your front door?" She has gotten much praise. And no one smokes in her home.

Hermine is remarkable in that she does not leave her interest in a smoke-free environment up to chance. She assures it before a foot crosses the threshold. ("I look out the window and watch service men take a last drag before they come in," she says with glee.) Hermine no longer has to rework and rediscuss this issue with all comers. The approach is almost 100 percent effective. You'd have to be out of your tree to light up in *that* house.

Hedda and Hermine fully acknowledge that living one's principles and maintaining the sanctity of one's home at social risk is a complex juggling act. The issues they tackled head-on are what make cowards of us all.

Conflicting values

The central issue is still that most fascinating of topics, what happens when two goods collide? How are decisions made when worthy values conflict? Are we physicians still, even at home, committed to the principles of promoting health? Or must we shed the mantle and be hosts like any other, socialized to give our guests what they want despite our personal wishes or comfort?

Enforcement of health rules at home may be seen as a gesture of benign autocracy, foisted upon an uncommitted and often unwilling acquaintance. Are we absolved of rudeness as long as we *meant* well? Or do the laws of hospitality demand that we proffer whatever a guest requires, even if it perforates his nasal septum, stinks up our draperies, moves him one inch closer to a size 42, or fills another bed at taxpayer's expense on the cancer wards of 1998. Similarly, our abandonment of the laws of politesse may be seen, not as enlightened self and social awareness, but a form of narcissism, in which we demand our health and its preservation the same way we might demand a material good or a creature comfort.

A related issue deals with the limits of our authority and the generalization of our expertise as professionals. Is it necessary for us to establish a contractual basis for our in-home restrictions, with both parties agreeing beforehand to the rules and regs of the new social game? If such a contract is *not* established, because we don't doubt that we can do what we darn please in our own digs, are we then justified in using our authority as physicians to justify our unilateral "assumption of power"? When we enforce hygienic rules in our home, for whose good is it, anyway?

Ethics and values aside, it is very likely that our decision making is based upon issues other than extensions of authority, benign paternalism, socialization norms, and narcissism. It may also be based on nothing more than primitive territorialism. And what does it say about our capacities for self-assertion rather than masochistic acquiescence to an unpleasant situation over which we feel we have no control! "I wouldn't have the nerve to say anything" sums up succinctly the attitudes of those who avoid making waves, lest they be put to the test of putting their principles or their friendships on the line. (In fact, Hermine reports that she and her husband have slowly weeded the smokers out of their circle of friends, for better or worse.)

Both of my friends distinguished themselves by unequivocally breaking the pattern of social acceptance and taking the risk of being thought unaccomodating. No one can say they don't know how to take charge of their lives. If it is true that strong men die but once, while cowards die a thousand deaths, the same can be said of people who bring their principles home. The issue is essentially fought out only once. Are they being shielded from the repercussions? Are guests not being as forthright as they in feeding back their true opinions? It is entirely possible. So be it.

Those who criticize the one for controlling her guests and monitoring their every mouthful, and the other for a unilateral, ungracious stand on an addiction that victimizes the smoker as well as the host, should at least recognize that they have become orators where the rest of us have pebbles in our mouths. They make me think that physicians should take some post-graduate courses in assertiveness training. Having mastered the art, they will be in a better position to pass judgments, and offer even more suitable alternatives for those awkward situations where expectations, desires, and aversions collide.□

capital commentary

Review of state delegates to 99th Congress

Robert H. Craig Jr.
Jerry L. Rothenberger
Larry L. Light

The convening of the 99th Congress this past January was exciting for the Pennsylvania Congressional Delegation. For the first time in several years one of their colleagues was to be named chairman of a full House committee. Many others also were rising to ranking positions on committees and subcommittees of the House. In fact, the Pennsylvania delegation has been maturing through seniority to a position that enables its members to assert significant influence on policy.

We've taken a look at the 23 Pennsylvania Congressmen and provided some information on their personal and political backgrounds, their districts, and their committee assignments.

First District—**Thomas M. Foglietta (D), Philadelphia County**

Voters in this heavily Democratic district have elected former Republican and independent Foglietta to his third term. Foglietta is an attorney and has also been on the Philadelphia City Council. He serves on the Armed Forces and the Merchant Marine and Fisheries Committees.

Second District—**William H. Gray III (D), Philadelphia County**

The second district is the most Democratic district in Philadelphia. Representative Gray is a Baptist minister who was first elected to Congress in 1978. Now in his fourth term, he was elected chairman of the powerful and prestigious Budget Committee in the 99th Congress and is the only committee chairman from Pennsylvania. As the Budget Committee chairman, he will be intricately involved in fiscal matters, including Medicare.

Third District—**Robert A. Borski Jr. (D), Philadelphia County**

This district includes the northeastern part of Philadelphia. Congressman Borski, now serving his second term, is a former stockbroker who served in the state House for six years. He is on the Select Committee on Aging (Subcommittee on Health and Long-Term Care), the Merchant Marine and Fisheries Committee, and the Public Works and Transportation Committee.

Fourth District—**Joseph P. Kolter (D), Armstrong, Beaver, Butler, Indiana, Lawrence, and Westmoreland Counties**

Congessman Kolter is now serving his second term from a district which surrounds Pittsburgh on two sides. He is a former member of the state House and the father of two physician sons. Kolter serves on the Government Operations and the Public Works and Transportation Committees.

Fifth District—**Richard T. Schulze (R), Chester, Delaware, and Montgomery Counties**

A small businessman, Schulze is now entering his sixth congressional term. He is a member of the Ways and Means Committee and was named the outstanding freshman during his first team in Congress. He is a former state legislator.

Sixth District—**Gus Yatron (D), Berks, Carbon, Lancaster, Schuylkill Counties**

Congressman Yatron was the only incumbent with no opponent in the 1984 election. He has been in Congress since 1969 and is serving his ninth term. He is a former member of both the state House and Senate. Congressman Yatron is a member of the House Foreign

Pennsylvania Delegation Committee Assignments

Appropriations	Coughlin, Gray, McDade, Murtha
Armed Forces	Foglietta
Banking, Finance, and Urban Affairs	Kanjorski, Ridge
Budget	Goodling, Gray (Chairman)
District of Columbia	Gray
Education and Labor	Gaydos, Goodling, Murphy
Energy and Commerce	Ritter, Walgren
Foreign Affairs	Kostmayer, Yatron
Government Operations	Clinger, Coughlin, Kolter, Walker
House Administration	Gaydos
Interior and Insular Affairs	Kostmayer, Murphy
Judiciary	Gekas
Merchant Marine & Fisheries	Borski, Foglietta
Post Office and Civil Service	Yatron
Public Works and Transportation	Clinger, Edgar, Kolter, Shuster, Borski
Science and Technology	Ritter, Walgren, Walker
Select on Aging	Borski, Gekas, Ridge
Select on Hunger	Kostmayer
Select on Narcotics Abuse and Control	Coughlin
Small Business	McDade
Veterans Affairs	Edgar, Kanjorski, Ridge
Ways and Means	Coyne, Schulze

The authors are the staff of the Council on Legislation. Mr. Craig is director, Mr. Rothenberger is assistant director, and Mr. Light is legislative liaison.

Affairs Committee (chairman, Human Rights Subcommittee) and the Post Office and Civil Service Committee.

***Seventh District*—Robert W. Edgar (D), Delaware and Philadelphia Counties**

Reelected by a narrow margin to his sixth term, Congressman Edgar is mentioned as likely to seek the Democratic nomination for the U.S. Senate in 1986. He is the chairman of the Hospitals and Health Care Subcommittee of the House Veterans Affairs Committee and a member of the Public Works and Transportation Committee. He is a Methodist minister.

***Eighth District*—Peter H. Kostmayer (D), Bucks and Montgomery Counties**

In 1982, Congressman Kostmayer defeated then incumbent James Coyne to reclaim the seat Kostmayer had held in Congress from 1976 to 1980. In 1980 Coyne had won a close race with 51 percent of the vote. Congressman Kostmayer is a former reporter and press aid to Governor Shapp. He is on the Foreign Affairs, the Interior and Insular Affairs, and the Select Hunger Committees.

***Ninth District*—E. G. "Bud" Shuster (R), Bedford, Blair, Cambria, Clearfield, Cumberland, Franklin, Fulton, Huntingdon, Juniata, and Mifflin Counties**

Bud Shuster was elected to Congress in 1972 and is now serving his seventh term. He is the author of *Believing in America* and holds a PhD from American University. Shuster serves on the Public Works and Transportation Committees. (He is ranking Republican member of the Surface Transportation Subcommittee.)

***Tenth District*—Joseph M. McDade (R), Bradford, Clinton, Lackawanna, Monroe, Pike, Potter, Susquehanna, Tioga, Wayne, and Wyoming Counties**

The senior member of the Pennsylvania delegation, Congressman McDade has more service than any Pennsylvanian from either party and has served in the U.S. House since 1962. He is the ranking Republican on the Small Business Committee and the second ranking Republican on the Appropriations Committee. McDade is an attorney and a native of Scranton.

***Eleventh District*—Paul Kanjorski (D), Carbon, Columbia, Luzerne, Monroe, Montour, Northumberland, and Sullivan Counties**

The only freshman in the Pennsylvania Congressional Delegation this session, Congressman Kanjorski is a 47-year old Wilkes-Barre attorney. He will be the fifth representative of the district since 1979, when the seat was vacated by Congressman Daniel Flood. Kanjorski defeated the previous Democratic incumbent in the 1984 primary. He has won appointments to the Veterans Affairs and the Banking, Finance, and Urban Affairs Committee.

***Twelfth District*—John P. Murtha (D), Armstrong, Cambria, Somerset, and Westmoreland Counties**

Murtha is one of the ten present congressmen who had previous service in the state legislature before moving on to the Congress. Representative Murtha is now entering his sixth term. The congressman is a veteran of Vietnam and Korea and is a colonel in the U.S. Marine Corps Reserve. He serves on the Appropriations Committee.

***Thirteenth District*—R. Lawrence Coughlin (R), Montgomery and Philadelphia Counties**

Coughlin has served his suburban Philadelphia district in the Congress since 1968. He is an attorney, a Yale graduate and a former Marine captain. Congressman Coughlin is a member of the House Appropriations Committee, the Select Committee on Narcotics Abuse and Control, and the Government Operations Committee. Before his election to the Congress, he served four years in the state House of Representatives.

***Fourteenth District*—William J. Coyne (D), Allegheny County**

Prior to his election to the Congress, Representative Coyne served in the state House and then on the Pittsburgh City Council. An accountant, he is a newly appointed member of the Ways and Means Committee. His district includes all of the city of Pittsburgh and several suburban areas.

***Fifteenth District*—Donald L. Ritter (R), Lehigh, Monroe, and Northampton Counties**

Noted as one of the few members of Congress with a scientific degree, Ritter represents a district composed of industrial Lehigh Valley. He defeated a long-time incumbent Democratic congressman in 1978 and has since been reelected to his fourth term. He serves on the Energy and Commerce and the Science and Technology Committees.

***Sixteenth District*—Robert S. Walker (R), Chester, Lancaster, Lebanon Counties**

A former congressional aide, Congressman Walker has been a vocal and tireless proponent of conservative issues on the House floor. He had been a teacher before going to work in Washington. Congressman Walker serves on the Government Operations Committee and the Science and Technology Committee, where he is the second ranking Republican member.

***Seventeenth District*—George W. Gekas (R), Dauphin, Lycoming, Northumberland, Perry, Snyder, and Union Counties**

When his predecessor decided to run for statewide office in 1982, thus creating a vacant seat, it was seized by Harrisburg attorney Gekas. He is now in his second term. Gekas is the ranking Republican on the Judiciary Subcommittee on Criminal Justice and also serves on the Select Committee on Aging. Congressman Gekas served for 16 years in the state legislature as a representative and a senator.

***Eighteenth District*—Doug Walgren (D), Allegheny County**

A Mt. Lebanon attorney, Congressman Walgren has been reelected by his suburban Pittsburgh constituents four times since he won victory in the district previously represented by U.S. Senator John Heinz. Walgren serves on the Energy and Commerce Committee and the Science and Technology Committee. (He is chairman of the Science Research and Technology Subcommittee.)

***Nineteenth District*—William F. Goodling (R), Adams, Cumberland, and York Counties**

This congressional seat has been in the Goodling family since 1961 when it was won by his father. The present incumbent is a former teacher and administrator who has attracted national attention for his refusal to accept political action committee contributions, although he did accept PAC funds in his first campaign. A member of the Budget Committee, Congressman Goodling is on the committee's Health Task Force and is the ranking Republican on the Human Resources Task Force. He is the second ranking Republican on the

Should you invest in convertible securities?

Vasilios J. Kalogredis, JD, CPBC
Susan F. Dubow, JD

There's been an increasing amount of attention paid to convertible securities. The idea behind these investments is that you start out by buying a "debt-type" investment, that is, a bond that can be converted into "equity," namely, common stock of the issuing company. These have been around for a while, but the attention they're attracting, as well as the number of issues available, are pretty new.

Should you invest in one of these? How are they as retirement plan investments? Before you come to any quick decisions, you should get a clear idea of what these things are, and what they can or cannot do.

Debt or equity?

Here's a fundamental question: Should a convertible be bought by someone who's basically shopping for a bond or by someone who's basically shopping for common stock? No question about it. Convertibles are for those whose primary interest is the common stock of a particular company. The interest rate paid by these issues will be less than that of the bonds issued by the same company. That's why the company is selling these to begin with, to get a lower interest loan. So if you want a bond, buy a bond.

Why would someone interested in common stock buy a convertible issue? Suppose you think the value of the company's common stock is going to go up. Since these issues can be converted into a set number of shares, the value of the convertible will go up with the value of the stock.

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But convertibles give much more protection in case the price of the common stock goes down. After all, these are still paying a fixed rate of interest, and that interest keeps the value from eating the dust when the stock price skids.

How much protection do you get? With some of the better convertibles, the price of the convertible will reflect about 90 percent of the increase in value of the underlying stock, but will only absorb 50 percent of any decreases. In short, what you get is a stock investment where you lose out on the highest highs, and in return you get a level of protection unknown to most stock investors.

A new lexicon

If you've read this far in the article it means you have at least some curiosity. Hang on a little longer while we define the terms you'll need to understand in order to evaluate a convertible issue.

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capital commentary

Education and Labor Committee. Goodling was elected to his first term in 1974.

***Twentieth District*—Joseph M. Gaydos (D), Allegheny and Westmoreland Counties**

This district could be considered the blue collar district of Pittsburgh. Representative Gaydos has served it since 1968. Formerly a labor attorney who has strong union backing, he is chairman of the Health and Safety Subcommittee of the Education and Labor Committee and the Accounts Subcommittee of the House Administration Committee.

***Twenty-first District*—Thomas J. Ridge (R), Crawford, Erie, Lawrence, and Mercer Counties**

After capturing an open district created by the retirement of the incumbent in 1982, Congressman Ridge has now been reelected for the first time. An attorney, Ridge serves on the Banking, Finance, and Urban Affairs Committee, the Veterans Affairs Committee, and the Select Committee on Aging (Health and Long-Term Care Subcommittee). He won his first election by less than 800 votes, the second by almost 2 to 1.

***Twenty-second District*—Austin J. Murphy (D), Allegheny, Beaver, Fayette, Greene, and Washington Counties**

The retirement in 1976 of the 32-year incumbent Thomas "Doc" Morgan, MD, gave then state Senator Murphy the opportunity to capture the Democratic nomination for this congressional seat. He has served the southwestern Pennsylvania district since that time. Murphy is on the Education and Labor Committee and the Interior and Insuler Affairs Committee. He is an attorney who began service as a state legislator in 1959.

***Twenty-third District*—William F. Clinger Jr. (R), Armstrong, Cameron, Centre, Clarion, Clearfield, Clinton, Elk, Forest, Jefferson, McKean, Venango, and Warren Counties**

This large, sprawling, and sparsely populated district covers the entire northcentral part of the state. Congressman Clinger defeated a one-term incumbent in 1978 and now has been reelected to his fourth term. He serves on the Public Works and Transportation and the Government Operations Committees of the House. He is the ranking Republican member of a subcommittee of each of these two committees.

Here is an unofficial analysis of occupations as listed by the 23 congressmen.

Attorney	12
Educator	2
Minister	2
Scientist	1
Accountant	2
Businessman	3
News reporter	1
Former state legislator	10

The 1985-1986 PaMPAC Legislative Directory contains all the information you will need to call or write your congressman. □

Conversion premium At the moment you buy a convertible, the price you pay for it usually will be greater than the value of the shares that you can convert it into. That excess is the premium you pay for the convertible privilege. If, for instance, you pay $1,200 for a bond that can be converted into common stock worth $1,000, the conversion premium is said to be 20 percent.

Well, you may be wondering, is a 20 percent conversion premium good or not? Usually 20 percent or less means it's a good investment, but there are other factors.

Yield advantage This is the difference between the interest paid on the convertible and the dividends paid on the underlying common stock. Suppose, in the hypothetical case above, the bond paid interest of 9 percent, and the stock that it could be converted into paid annual dividends of 5 percent. The yield advantage is this extra 4 percentage points that you're getting for buying the convertible rather than the common stock.

Break-even time In the example we're using, if the bonds pay 4 percentage points more than the stock, but cost 20 percent more to buy, then it takes five years for the bond buyers to break even, that is, to reach the point they'd be at for buying the stock from the start.

For many investors, this break-even time is critical. If it's more than three years (as in our example), you should approach the investment with caution, since the longer the break-even time is the less likely that increases in the value of the underlying common stock will be reflected in the value of the convertible. Recently, median break-even times have hovered around 2.7 years. If you're looking at a convertible with that kind of break-even time or less, you've got an investment that will pretty safely follow on the coattails of the issuing company's common stock.

What if there's a company you're interested in, and you want to go the convertible securities route, but the break-even time is well over three years? Don't fret. The break-even time may change, as the underlying factors change. After all, the price of a stock is a lot more volatile than the price of a bond, even a convertible bond. If the value of the stock jumps up at a faster pace than the bond, this effectively narrows the conversion premium. And the smaller the conversion premium, the shorter the break-even time. So if you're not happy with a particular convertible being offered but are optimistic about the underlying stock, just wait. If the stock goes up, the convertible might end up being a better buy. And if the stock doesn't go up, you're just as well not to have made the investment.

In fact, convertibles are getting to be better buys for the most part. Remember they're here because companies want to issue them. In the months ahead, you shouldn't be surprised if the supply of convertible securities greatly outstrips demand—they're still esoteric. As the supply increases, companies will have to make them more attractive by giving them a higher yield advantage, while sellers will have to settle for a lower conversion premium.

Risks

Risk number one is that interest rates generally will rise. This has a double effect on convertible securities. As fixed-income investments, the resale value shrinks to take into account the fact that better interest rates are available elsewhere. And, interest rate increases may have an adverse effect on the underlying stock, in which case the conversion privilege won't be worth much. The yield keeps these securities from dropping in value as low as the common stock, but there still will be a substantial reduction in value.

Another risk is that the company may have the right to "call" these securities, that is, prepay the debt, as it could have with any kind of debt instrument. If you're looking into convertibles, make sure you're buying into one that has some kind of protection against arbitrary calls. For instance, such protection might provide a minimum amount of time that has to elapse before the call can be exercised, or a certain amount in excess of the call price that the value of the convertible has to go before the company can in fact call it. If you don't get some kind of call protection, the investment could turn out to be a bond that cost too much, and yielded too little—something that's especially distressing when you consider your original motivation was to invest in a company's equity.

Ways to invest

Rumor has it that convertible securities are going to be a hot item among pension investors. All in all, however, that's probably not a good idea for many doctors. With a tax-deferred pension or profit sharing plan you're looking for a high return that would otherwise be taxable. These bonds have a lower return than straight bonds of comparable quality and any profit you may get (if the underlying stock goes up in value) is taxed as capital gains—in short, you don't need the tax shelter of the tax qualified plan. If you like a company and want to put it in the plan, invest in the company's regular bonds with their higher returns to be most conservative. However, for those doctors interested in some element of equity investment in their pension plans, convertibles can be a good way to go.

Convertible issues make a lot of sense as part of your personal portfolio. They're perfect for the novice stock market investor who may have the hunger but not the stomach for the ups and downs of the stock market. Or, for someone who's saving for a particular goal, and doesn't want to lose it all in some bad stocks. You may want to do some retirement saving outside your tax-sheltered plan, and this would be a perfect investment for that kind of saving. Also, if you're accumulating money for the purchase of a home or for a child's college tuition, and you want to put some part of those savings into investments more aggressive than money market accounts (but less aggressive than common stocks) then these issues could be just what you're looking for.

The next time you're thinking about investing in the stock market, talk with your broker about companies that issue convertibles. Run through the analysis we've given here in order to determine whether a particular convertible issue is a good buy. If so, go ahead and make the purchase. If the underlying stock goes up in value, you can either make a profit on the appreciated convertible, or actually convert it into the stock. If the price of the underlying stock goes down, the convertible will go down at a much slower rate. □

medical feature

HTLV-III alternate test sites and counseling program

The Acquired Immune Deficiency Syndrome (AIDS) has emerged in the last four years to become one of the most serious epidemic disease problems in recent history. It has been designated the nation's number one health problem by Health and Human Services Secretary Margaret Heckler and consumes an increasing proportion of the nation's health resources. Control of the epidemic is made especially difficult because of major social issues raised by groups at high risk for AIDS and because the virus which causes the disease is frequently transmitted by blood and blood products.

Clinical AIDS and the accompanying severe life threatening infections represent the most severe manifestation of infection by Human T Lymphotrophic Virus Type III (HTLV-III). This virus is transmitted by needle sharing, blood and blood products, homosexual or heterosexual sexual contact, and transplacentally or perinatally. It is not transmitted by casual workplace contact, hospital contact or by non-intimate family contact.

It specifically attacks certain classes of precursor white blood cells. The resulting infection, which frequently becomes a persistent or chronic one, results in varying degrees of malfunction of the cellular and humoral immune system. Infected persons may remain asymptomatic for long periods (at least 4 years) or may develop AIDS related complex (ARC) including lymphadenopathy syndrome (LAS) or frank AIDS within 1-3 years. The proportion of antibody positive homosexual men developing these syndromes when followed for several years was 10-30% for ARC and 5-20% for AIDS.

Antibody testing

Recently, an ensyme linked immunosorbent assay (ELISA) has been developed for measuring antibody to HTLV-III virus. This test is currently in use as a screening test in most blood banks in Pennsylvania. Preliminary testing indicates the test to be 90-99% sensitive for detection of antibody in patients with AIDS and ARC and 99.3-99.8% specific. The sensitivity of the test for detection of antibody in asymptomatic, virus positive people is not known. The predictive value of a positive test is a critical aspect of the test because of the large psychological, emotional and potential economic impact of a false positive test. The predictive value of a positive test depends on the actual rate of seropositivity in the population. If the person is a member of a high risk group in which the antibody prevalence is 50% then there will only be 1% false positives and the predictive value of the test is 99%. If the antibody prevalence in a risk group is 20% or 10% there will be 4% and 8.7% false positives and the predictive value of a positive test would be 96% and 91.3% respectively.

The problem of false positive tests becomes larger when blood donors from low risk groups are found to have a positive test. When the actual antibody prevalence is less than 1%, as it appears to be in the general population which donates blood, the predictive value of a positive test becomes less than 50% and the proportion of false positives is above 50%. Thus, a great deal of caution must be used in interpretation of such a test result and a frank discussion by a medical care provider with the person whose test is positive is indicated.

Significance of positive test

We do not yet know what proportion of people in groups at low or high risk for AIDS become chronically infected following exposure to HTLV-III virus or what proportion will develop ARC or AIDS if longer-term follow up is carried out. We do not know what proportion of people with a true positive test for HTLV-III antibody in low or high risk groups are persistently or intermittently virus positive in blood, semen, saliva or other bodily fluids, or what proportion can transmit virus to others by any of the above body secretions. Preliminary data from high *and* low risk groups indicates that a high proportion of antibody positive individuals also have virus in their blood. It is clear that true antibody positive people are at higher risk of developing AIDS and of transmitting HTLV-III virus than are antibody negative people; HTLV-III antibody status is a significant personal medical fact as well as a serious public health one.

Recommendations

In January 1985, the Public Health Service (PHS) published its recommendations for screening donated blood and plasma for antibody to the virus (HTLV-III) causing AIDS. (See accompanying article from *MMWR* January 11, 1985.) This Inter-Agency plan was developed to protect the nation's blood supply and reduce the risk of transmission of HTLV-III virus by blood products. In February 1985, the Food and Drug Administration (FDA) sent a memorandum to all registered blood banks notifying them of the imminent licensure of tests to detect antibody to HTLV-III virus and recommending that provision be made for medical follow-up and donor counseling by blood banks and for establishment of alternate test sites where individuals concerned for their past exposure to HTLV-III virus might obtain test results without donating blood. This FDA memorandum also made recommendations to blood banks concerning donor

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nformed consent, donor deferral registers, donor notification and confidentiality protocols, definition of test results, confirmatory tests, revision of procedure manuals, and blood product labeling.

Alternate test sites and counseling

After the above PHS and FDA documents were issued, the Centers for Disease Control announced the availability of federal funds for the establishment of alternate testing sites to perform Human T Lymphotrophic Virus Type III (HTLV-III) antibody testing. The state of Pennsylvania applied for and successfully acquired funds to begin alternate site testing and/or counseling programs in counties where most AIDS cases had been reported statewide. Beginning July 1, 1985, and lasting 6 months, blood drawing and testing as well as confidential notification of results and counseling will be available at four sites in Philadelphia, 2 sites in Allegheny County, at the Chester, Norristown and Reading State Health Centers and at the Erie County Health Department and the Allentown Bureau of Health. Counseling only and referral to sites for blood drawing will be available at the Chester County Health Department (West Chester) and Bethlehem City Health Department. The coordinators of these testing sites will perform pre and post test counseling, coordinate specimen collection and obtaining the lab results and provide public and professional information and education materials.

Professional, medical, or public health personnel wishing to receive further information or contact the HTLV-III counseling coordinator at any of the alternate test or counseling sites should contact the local health jurisdictions at the following numbers:

City	Telephone	Reference Person
Philadelphia	215-686-5117	Barbara Ward
Pittsburgh	412-578-8332	Bill Holder
Erie	814-454-5811	Terry Kalgren
Allentown	215-437-7725	Barbara Stader
West Chester	215-431-6465	Sally Sievila
Bethlehem	215-865-7087	Glen Cooper
Chester	215-447-3250	Marian Henry
Norristown	215-270-3616	Debbie Schmidt
Reading	215-378-4350	Betty Powers
	215-378-4377	Anne Evans

Testing for HTLV-III antibody is available to physicians from:

Regional Clinical Laboratory	Damon Clinical Laboratory
1526 Peach Street	3190 Tremont Avenue
Erie, PA 16501	Trevose, PA 19047
(814) 453-3611	(215) 632-4100

Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing Acquired Immunodeficiency Syndrome

(Reprinted from MMWR, January 11, 1985)

In March 1983, the U.S. Public Health Service issued inter-agency recommendations on the prevention of acquired immunodeficiency syndrome (AIDS).[1] Included was the recommendation that members of groups at increased risk for AIDS should refrain from donating plasma and/or blood. That recommendation was made to decrease the risk of AIDS associated with the administration of blood or blood products, which accounts for about 2% of all reported AIDS cases in the United States.

Evidence has shown that a newly recognized retrovirus is the cause of AIDS. Although this virus has been given several names, including T-lymphotropic virus type III (HTLV-III)[2] lymphadenopathy-associated virus (LAV)[3], and AIDS-associated retrovirus (ARV)[4], it is referred to as HTLV-III in this discussion. Tests to detect antibody to HTLV-III will be licensed and commercially available in the United States in the near future to screen blood and plasma for laboratory evidence of infection with the virus. The antibody tests are modifications of the enzyme-linked immunosorbent assay (ELISA), which uses antigens derived from whole disrupted HTLV-III.[5]

There is considerable experience with the ELISA test in research laboratories, but much additional information will be gathered following its widespread application. In the early phases of testing, a number of false-positive tests may be encountered. Adjustments in interpretation are anticipated as more is learned about the performance of the test in an individual laboratory and about the specific proportion of falsely positive or falsely negative tests in the screening setting where the test is used.

The present recommendations concern the use of these tests to screen blood and plasma collected for transfusion or manufactured into other products. They are intended to supplement, rather than replace, the U.S. Food and Drug Administration's recently revised recommendations to blood and plasma collection facilities and the earlier inter-agency recommendations[1]. Additional public health applications of these tests in the understanding and control of AIDS will be described in a subsequent report.

BACKGROUND

Antibody detection studies

The ELISA test has been used in many research programs for detecting antibodies to HTLV-III in patients with AIDS and with AIDS-related conditions. In different studies, HTLV-III antibody was found to range from 68% to 100% of patients with AIDS, and in 84%-100% of persons with related conditions, such as unexplained generalized lymphadenopathy[5-7]. Serologic surveys have yielded variable seropositivity rates in groups at increased risk for AIDS: 22%-65% of homosexual men[8-11], 87% of intravenous-drug abusers admitted to a detoxification program in New York City[12], 56%-72% of persons with hemophilia A[13,14], and 35% of women who were sexual partners of men with AIDS.[15] In contrast to the above groups, HTLV-III antibody has been detected in fewer than 1% of persons with no known risks for AIDS.[4-10]

The time needed to develop a positive antibody test following infection is not known. Data regarding the interval between infection with HTLV-III and seroconversion are limited. A nurse who sustained a needle-stick injury while caring for an AIDS patient developed antibody between 4 and 7 weeks following exposure.[16] Additionally, a recent study described several asymptomatic individuals infected with HTLV-III for more than 6 months in the absence of detectable antibody.[17,18] Nonetheless, currently available ELISA tests can be expected to identify most persons with HTLV-III infection.

Virus isolation studies

HTLV-III has been isolated from blood, semen, and saliva and has been recovered from many individuals in the presence of antibody.[19,20] HTLV-III has been isolated from the blood of 85% or more of seropositive individuals with AIDS,[21] lymphadenopathy, or other AIDS-associated conditions[2] and from three of four mothers of infants with AIDS.[2] The virus has also been isolated from asymptomatic seropositive high-risk blood donors who had been implicated in the transmission of AIDS through transfusion.[21] The recovery of HTLV-III from these high-risk donors 2 or more years after the initial donation provides evidence that viremia may persist for years in both asymptomatic and symptomatic individuals. HTLV-III has also been isolated from asymptomatic seronegative persons, but this is the exception.[17]

Modes of transmission

Epidemiologic data suggest that the virus has been transmitted through intimate sexual contact; sharing contaminated needles; transfusion of whole blood, blood cellular components, plasma, or clotting factor concentrates that have not been heat treated; or from infected mother to child before, at, or shortly after the time of birth. No other prod-

ucts prepared from blood (e.g., immunoglobulin, albumin, plasma protein fraction, hepatitis B vaccine) have been implicated, nor have cases been documented to occur through such common exposures as sharing meals, sneezing or coughing, or other casual contact.

Natural history of infection

Information about the course of infection with HTLV-III is incomplete, but the majority of infected adults will not acquire clinically apparent AIDS in the first few years after infection. In some studies 5%-19% of seropositive homosexual men developed AIDS within 2-5 years after a previously collected serum sample was retrospectively tested and found to be seropositive. An additional 25% developed generalized lymphadenopathy, oral candidiasis, or other AIDS-associated conditions within the same interval.[11,22] The long-term prognosis for most persons infected with HTLV-III is unknown.

SCREENING BLOOD AND PLASMA

Initial testing

Persons accepted as donors should be informed that their blood or plasma will be tested for HTLV-III antibody. Persons not wishing to have their blood or plasma tested must refrain from donation. Donors should be told that they will be notified if their test is positive and that they may be placed on the collection facility's donor deferral list, as is currently practiced with other infectious diseases, and should be informed of the identities of additional deferral lists to which the positive donors may be added.

All blood or plasma should be tested for HTLV-III antibody by ELISA. Any blood or plasma that is positive on initial testing must not be transfused or manufactured into other products capable of transmitting infectious agents.

When the ELISA is used to screen populations in whom the prevalence of HTLV-III infections is low, the proportion of positive results that are falsely positive will be high. Therefore, the ELISA should be repeated on all seropositive specimens before the donor is notified. If the repeat ELISA test is negative, the specimen should be tested by another test.

Other testing

Other tests have included immunofluorescence and radioimmunoprecipitation assays, but the most extensive experience has been with the Western blot technique,[22] in which antibodies can be detected to HTLV-III proteins of specific molecular weights. Based on available data, the Western blot should be considered positive for antibody to HTLV-III if band p24 or gp41 is present (alone or in combination with other bands).

Notification of donors

If the repeat ELISA test is positive or if other tests are positive, it is the responsibility of the collection facility to ensure that the donor is notified. The information should be given to the donor by an individual especially aware of the sensitivities involved. At present, the proportion of these seropositive donors who have been infected with HTLV-III is not known. It is, therefore, important to emphasize to the donor that the positive result is a preliminary finding that may not represent true infection. To determine the significance of a positive test, the donor should be referred to a physician for evaluation. The information should be given to the donor in a manner to ensure confidentiality of the results and of the donor's identity.

Maintaining confidentiality

Physicians, laboratory and nursing personnel, and others should recognize the importance of maintaining confidentiality of positive tests results. Disclosure of this information for purposes other than medical or public health could lead to serious consequences for the individual. Screening procedures should be designed with safeguards to protect against unauthorized disclosure. Donors should be given a clear explanation of how information about them will be handled. Facilities should consider developing contingency plans in the event that disclosure is sought through legal process. If donor deferral lists are kept, it is necessary to maintain confidentiality of such lists. Whenever appropriate, as an additional safeguard, donor deferral lists should be general, without indication of the reason for inclusion.

Medical evaluation

The evaluation might include ELISA testing of a follow-up serum specimen and Western blot testing, if the specimen is positive. Persons who continue to show serologic evidence of HTLV-III infection should be questioned about possible exposure to the virus or possible risk factors for AIDS in the individual or his/her sexual contacts and examined for signs of AIDS or related conditions, such as lymphadenopathy, oral candidiasis, Kaposi's sarcoma, and unexplained weight loss. Additional laboratory studies might include tests for other sexually transmitted diseases, tests of immune function, and where available, tests for the presence of the virus, such as viral culture. Testing for antibodies to HTLV-III in the individual's sexual contacts may also be useful in establishing whether the test results truly represent infection.

RECOMMENDATIONS FOR INDIVIDUAL

An individual judged most likely to have an HTLV-III infection should be provided the following information and advice:

1. The prognosis for an individual infected with HTLV-III over the long term is not known. However, data available from studies conducted among homosexual men indicate that most persons will remain infected.

2. Although asymptomatic, these individuals may transmit HTLV-III to others. Regular medical evaluation and follow-up is advised, especially for individuals who develop signs or symptoms suggestive of AIDS.

3. Refrain from donating blood, plasma, body organs, other tissue, or sperm.

4. There is a risk of infecting others by sexual intercourse, sharing of needles, and possibly, exposure of others to saliva through oral-genital contact or intimate kissing. The efficacy of condoms in preventing infection with HTLV-III is unproven, but the consistent use of them may reduce transmission.

5. Toothbrushes, razors, or other implements that could become contaminated with blood should not be shared.

6. Women with a seropositive test, or women whose sexual partner is seropositive, are themselves at increased risk of acquiring AIDS. If they become pregnant, their offspring are also at increased risk of acquiring AIDS.

7. After accidents resulting in bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.

8. Devices that have punctured the skin, such as hypodermic and acupuncture needles, should be steam sterilized by autoclave before reuse or safely discarded. Whenever possible, disposable needles and equipment should be used.

9. When seeking medical or dental care for intercurrent illness, these persons should inform those responsible for their care of their positive antibody status so that appropriate evaluation can be undertaken and precautions taken to prevent transmission to others.

10. Testing for HTLV-III antibody should be offered to persons who may have been infected as a result of their contact with seropositive individuals (e.g., sexual partners, persons with whom needles have been shared, infants born to seropositive mothers).

Revised recommendations will be published as additional information becomes available and additional experience is gained with this test.

Hypogammaglobulinemia arthritis—case report

P.E. Dross, MD
B.L. Wilchusky, MD

Figure 1 A plain film of the right knee shows marked osteoporosis and soft tissue swelling.

Figure 2 There is marked demineralization of the left wrist. Erosions of the metacarpal joints and carpal bones are seen.

Figure 3 Findings similar to those in the other figures involve the right ankle.

Classically, rheumatoid arthritis is characterized by a nonsuppurative inflammation of synovial joints with infiltration of the synovium by chronic inflammatory cells (lymphocytes or plasma cells predominating).[6] It involves the peripheral and axial skeleton with a predilection for the metacarpophalangeal joints and proximal interphalangeal joints of the hands and feet. The knees, elbows, shoulders, and ankles also may be involved, usually in a symmetric distribution. We recently evaluated a patient with acquired hypogammaglobulinemia who developed a rheumatoid-like arthritis.

Case report

A 39 year old white male was admitted after an auto accident with fractures of the left humerus, clavicle, and right patella. He gave a history of repeated colds and pneumonia in childhood, and more recently, over the past 4-5 years, had frequent lower respiratory infections. During a previous hospitalization, the patient was found to be hypogammaglobulinemic. Serum protein electrophoresis showed low gamma globulin 0.28 (0.89-1.61). Immunoglobulins were IgG—0 (800-1800), IgA—0 (90-450), and IgM—less than 10 (50-250).

During his admission, the patient was placed on biweekly human gamma globulin injections and on alternating broad spectrum antibiotic prophylaxis. The patient later was noted to have arthritic complaints. The RA and ANA titers were negative, and C3 and C4 were normal. The patient had no psoriasis, urethritis, conjunctivitis, or balanitis. Serum IgG was 72 (600-1900), IgA—13.5 (61-330), and IgM—less than 3.5 (47-147). Synovial biopsy of the right knee showed chronic inflammation of the synovium. Stains for bacteria and fungi were negative. Joint fluid showed no inflammatory cells (nucleated cells or leukocytes) and no C3 or C4. The Ropes test (mucin clot test) revealed a poor mucin clot. Joint fluid also showed a negative rheumatoid factor and IgG—0, IgA—0, and IgM—0. Cultures for bacteria and fungi were negative.

Plain film findings consisted of marked osteoporosis and soft tissue swelling involving the right knee (Figure 1). The left wrist showed marked demineralization, erosion of the intercarpal joints and carpal bones, and erosion of the distal radius (Figure 2). Similar findings were seen in the right elbow, right shoulder, and right ankle (Figure 3). The patient was discharged and treated with human gamma globulin injections, gold, and ASA.

Discussion

Hypogammaglobulinemia may be congenital or acquired. The most common form is selective IgA deficiency, which occurs with a frequency of 1 in 600 of the general population.[1] Many of these patients will relate having had a history of a certain acute or subacute

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An adult patient with acquired hypogammaglobulinemia and associated seronegative deforming arthritis was studied. Serum immunoglobulin levels were tested and synovial tissue and fluid were examined histologically revealing chronic synovial inflammation. Plain film findings consisted of an asymmetric, rheumatoid-like arthritis involving the wrist, shoulder, elbow, ankle, and knee. This case is unusual in that erosive changes were seen; usually hypogammaglobulinemia arthritis is believed to be non-erosive. This case also confirms that patients with hypogammaglobulinemia may develop a polyarthritis which in many aspects is similar to rheumatoid arthritis, although there may be distinctly different pathogenic mechanisms in the two types.

disease process that seemed to have been associated with the appearance of agammaglobulinemia.[7] Zinneman *et al.*[23] described a case associated with sarcoidosis, and Provisor *et al.*[10] reported acquired agammaglobulinemia in three males after infectious mononucleosis. Our patient related having had numerous lower respiratory infections prior to the diagnosis of acquired hypogammaglobulinemia.

As many as one third of patients with hypogammaglobulinemia will develop a connective tissue disease[12] which commonly takes the form of an oligoarthritis with prominent synovial proliferation and effusion.[11] This chronic inflammatory polyarthritis has many clinical and histologic features of rheumatoid arthritis.[5] The histologic features of chronic synovitis are variable as the synovium may be with or without infiltration by lymphocytes. The synovial fluid may or may not be inflammatory. Taborn[11] reported a case in which the synovial fluid was devoid of infiltrating inflammatory cells or complement deposition as was our 39 year old patient.

The pathogenic mechanisms in the joint changes seen with hypogammaglobulinemia arthritis and the mechanisms in that of classical rheumatoid arthritis may be distinctly different. Chattopadhyay *et al.*[3] reported that a patient with X-linked hypogammaglobulinemia showed excessive suppressor T-cell activity of the lymphocytes from the rheumatoid synovial tissue and in the peripheral blood lymphocytes. This was distinctly different from the findings in the lymphocytes from synovial tissues of patients with classical rheumatoid arthritis which were deficient in suppressor T-cell activity. These findings supported the existence of different pathogenic mechanisms in the two types of rheumatoid inflammation.

The arthritis of hypogammaglobulinemia occurs most commonly in the knees, but may also affect the wrists, ankles, and fingers.[11] Pain is usually minor and joint effusion is prominent. Subcutaneous nodules, although rare, have been reported.[2] Roentgenograms may show juxta-articular osteoporosis and loss of cartilage as well as soft tissue swelling from joint effusion. Erosion and joint destruction are rare.[4] Our patient demonstrated the above radiographic findings, although he was unusual in that erosions were more prominent than in other reported cases.

These patients usually are treated with human gamma globulin. Reports have been both favorable and unfavorable. No improvement was seen in 4 of 50 hypogammaglobulinemic patients in the largest study on this subject,[8] while good improvement was seen in three arthritic, severely hypogammaglobulinemic patients.[9] Our patient responded well to gamma globulin treatment.

We conclude that the arthritis associated with hypogammaglobulinemia is quite variable and rare. In some patients, the arthritis histologically may resemble rheumatoid arthritis. Radiologically and clinically, the arthritis of hypogammaglobulinemia occurs most often in the knees, but it may also occur in the wrists, ankles, fingers, and shoulders. Juxta-articular osteoporosis, loss of cartilage as well as soft tissue swelling from joint effusion are common. Erosion, joint destruction and subcutaneous nodules are rare. The arthritis of immunoglobulin deficiency disease can be mild to moderate or can be severe in nature. The patient may or may not respond favorably to gamma globulin therapy.

Hypogammaglobulinemia arthritis may be suspected in patients with a history of certain acute or subacute disease processes followed by the appearance of hypogammaglobulinemia and an arthritis with many radiologic features similar to rheumatoid arthritis.□

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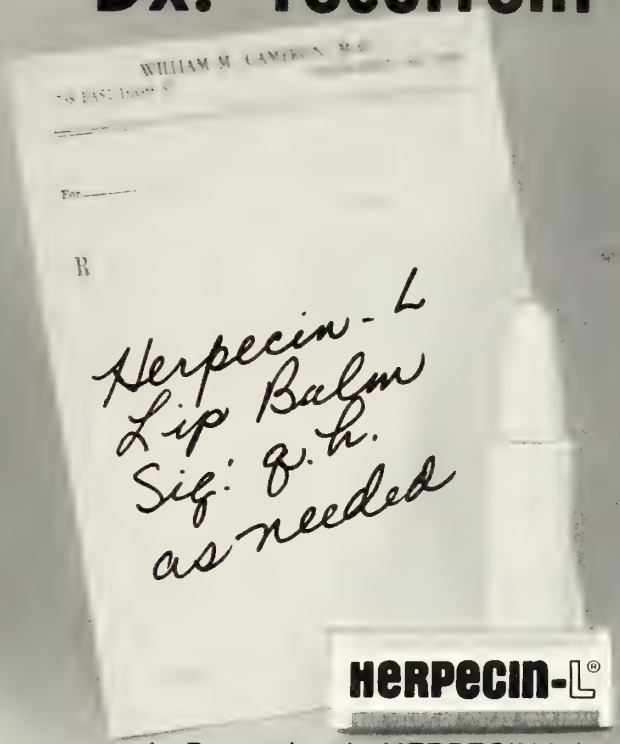

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CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

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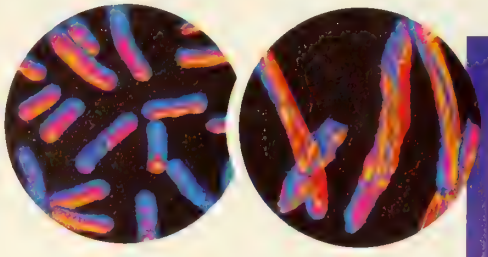

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before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

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acute exacerbations of chronic bronchitis
and acute otitis media

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Please see preceding page for a summary of product information.

Pennsylvania Medicine

Volume 88, No. 8 AUGUST 1985

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sleep that satisfies

Please see following page for references and summary of product information.

References: **1.** Greenblatt DJ, Allen MD, Shader RI *Clin Pharmacol Ther 21*:355-361, Mar 1977 **2.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **3.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **4.** Kales J, *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **5.** Kales A, *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **6.** Kales A, *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982 **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC, *et al: Behav Med*, pp. 25-31, Oct 1978

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage. Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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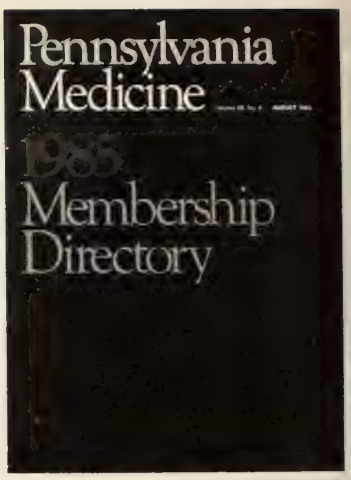

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Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g. dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C: INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Official Call to 1985 Meeting of PMS House of Delegates

The 1985 annual meeting of the House of Delegates of the Pennsylvania Medical Society will be called to order at the Bellevue Stratford Hotel, Philadelphia, Pennsylvania, on Friday, October 25, 1985, at 10:00 a.m. The second session of the House of Delegates is scheduled for Saturday, October 26, 1985, at 1:00 p.m. The third and concluding session of the House of Delegates will be held Sunday, October 27, 1985, at 9:30 a.m.

Elections

In accordance with Chapter XIII, Section 1 of the Bylaws of the Pennsylvania Medical Society, the following nominations and/or elections will be in order at the second session, Saturday afternoon, October 26, 1985.

General officers to be elected are a vice president, a secretary, a speaker of the House of Delegates, and a vice speaker of the House of Delegates.

In accordance with Chapter XV, Section 5 of the Bylaws, elections will be in order for a trustee for the Sixth District to serve three (3) years to succeed Betty L. Cottle, MD, Blair County, who is eligible for reelection; a trustee for the Seventh District to serve three (3) years to succeed Irving Williams III, MD, Union County, who is eligible for reelection; a trustee for the Tenth District to serve three (3) years to succeed Robert J. Carroll, MD, Allegheny County, who is eligible for reelection; a trustee for the Twelfth District to serve three (3) years to succeed Gerald L. Andriole, MD, Luzerne County, who is not eligible for reelection; a specialty society trustee to serve (3) years to succeed Martin A. Murcek, MD, who is eligible for reelection; and a resident physician trustee to serve two (2) years to succeed Barbara Shelton, MD, who is not eligible for reelection.

In accordance with Chapter XI, Section 1 of the Bylaws, elections for eight (8) delegates and eight (8) alternate delegates to the American Medical Association are in order. The term is for two (2) years beginning January 1, 1986 and expiring December 31, 1987. In addition, it will be necessary to elect one (1) delegate and one (1) alternate delegate for a partial term beginning October 27, 1985 and expiring December 31, 1986. In accordance with Standing Rule Number 10 (adopted October 22, 1982), the House will receive nominations for the eight (8) alternate delegates and the one (1) alternate delegate for a partial term following the results of the election of the eight (8) delegates and the one (1) delegate for a partial term. Elections for delegates will be held on Saturday afternoon, October 26, 1985, and elections for the alternate delegates will be held on Sunday morning, October 27, 1985. Delegates whose terms expire December 31, 1985 are:

1. Gerald L. Andriole, MD (Luzerne County)
2. Robert J. Carroll, MD (Allegheny County)
3. Joseph N. Demko, MD (Lackawanna County)
4. Henry H. Fetterman, MD (Lehigh County)
5. George Ross Fisher III, MD (Philadelphia County)
6. Matthew Marshall Jr., MD (Allegheny County)
7. Robert N. Moyers, MD (Crawford County)
8. R. Robert Tyson, MD (Philadelphia County)

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for eight (8) delegates for two (2) year terms commencing January 1, 1986:

1. Gerald L. Andriole, MD (Luzerne County)
2. Robert J. Carroll, MD (Allegheny County)
3. Joseph N. Demko, MD (Lackawanna County)
4. Henry H. Fetterman, MD (Lehigh County)
5. George Ross Fisher III, MD (Philadelphia County)
6. Matthew Marshall Jr., MD (Allegheny County)
7. Robert N. Moyers, MD (Crawford County)
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The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for delegate for a partial term commencing October 27, 1985, and expiring December 31, 1986:

1. Donald C. Brown, MD (Westmoreland County)
2. Donald E. Parlee, MD (Bucks County)

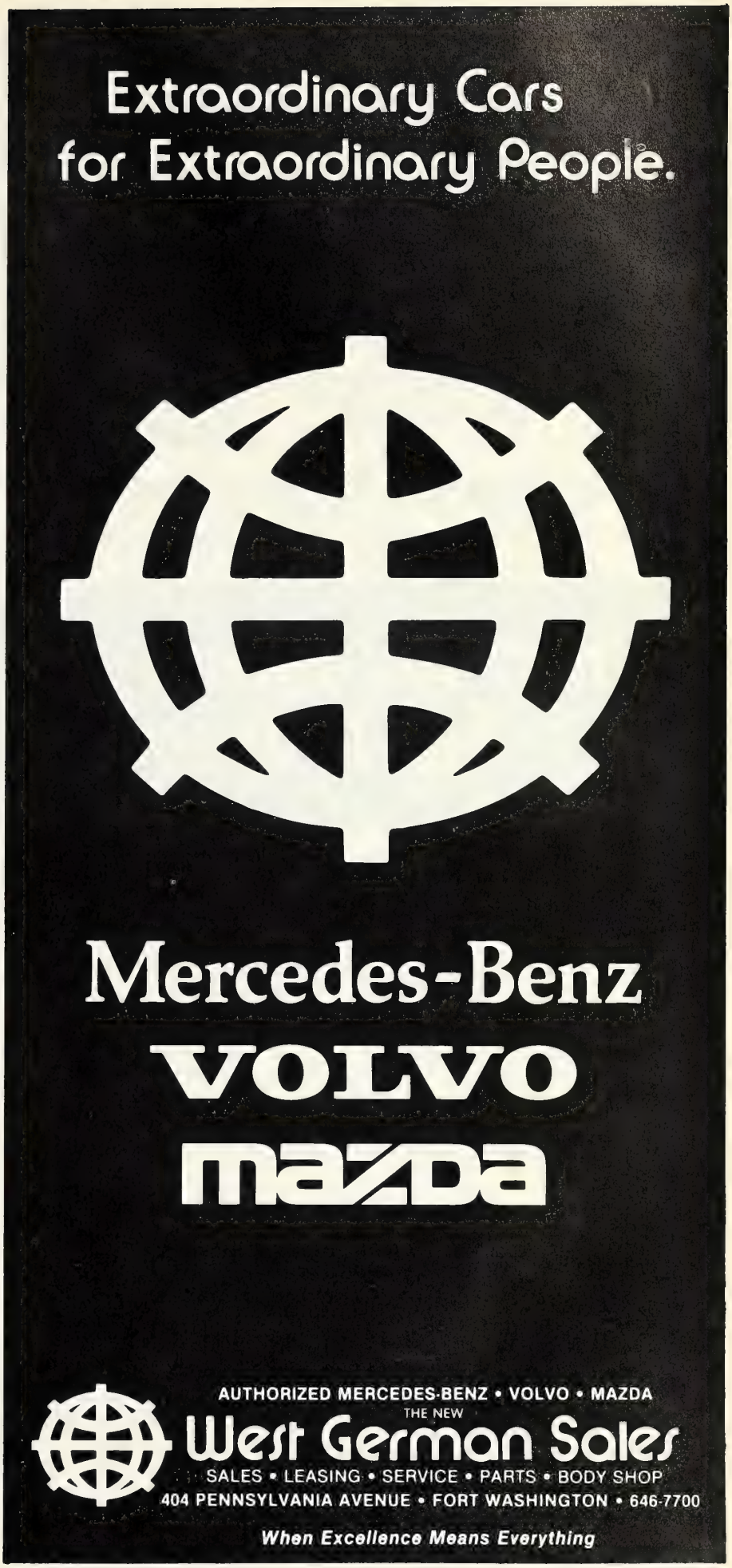
Alternate delegates whose terms expire December 31, 1985 are:

1. Doris G. Bartuska, MD (Philadelphia County)
2. Joseph B. Blood Jr., MD (Bradford County)
3. Donald C. Brown, MD (Westmoreland County)
4. Paul F. Kase, MD (Dauphin County)
5. Donald E. Parlee, MD (Bucks County)
6. James A. Raub, MD (Allegheny County)
7. Alan H. Schragger, MD (Lehigh County)
8. Barbara Shelton, MD (Philadelphia County)

The Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for eight (8) alternate delegates for two (2) year terms commencing January 1, 1986, and one (1) alternate delegate for a partial term commencing October 27, 1985, and expiring December 31, 1986:

1. Mary C. Barton, MD (Dauphin County)
2. Doris G. Bartuska, MD (Philadelphia County)
3. Brenda K. Baumann, MD (Clearfield County)
4. Joseph B. Blood Jr., MD (Bradford County)
5. Susan H. Bray, MD (Philadelphia County)
6. Richard E. Deitrick, MD (Allegheny County)
7. Victor F. Greco, MD (Luzerne County)
8. Roberta L. Schneider, MD (Montgomery County)
9. Alan H. Schragger, MD (Lehigh County)
10. Barbara Shelton, MD (Philadelphia County)
11. Donald H. Smith, MD (Northampton County)
12. William J. West, MD (Cumberland County)

Also to be elected will be two mem-



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bers to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. The term of Thomas J. Kardish, MD, Bucks County, expires; he is eligible for reelection. The term of Edward J. Notari, MD, Lackawanna County, expires; he is eligible for reelection.

In accordance with Chapter XVIII, Section 2 of the Bylaws, the Board of Trustees nominates the following members for two vacancies on the Judicial Council: For the office now held by William A. Limberger, MD, Chester County, the Board nominates Wilbur E. Flannery, MD, Lawrence County; Leroy A. Gehris, MD, Berks County; and Michael P. Levis, MD, Allegheny County. For the office now held by Joseph M. Stowell, MD, Blair County, the Board nominates F. Gregg Ney, MD, Butler County; George A. Rowland, MD, Columbia County; and Joseph M. Stowell, MD, Blair County.

Proposed bylaws amendments

Set forth below is the text of the proposed Bylaws amendments. Deletions from existing Bylaws are indicated by brackets; additions are italicized.

Subject One

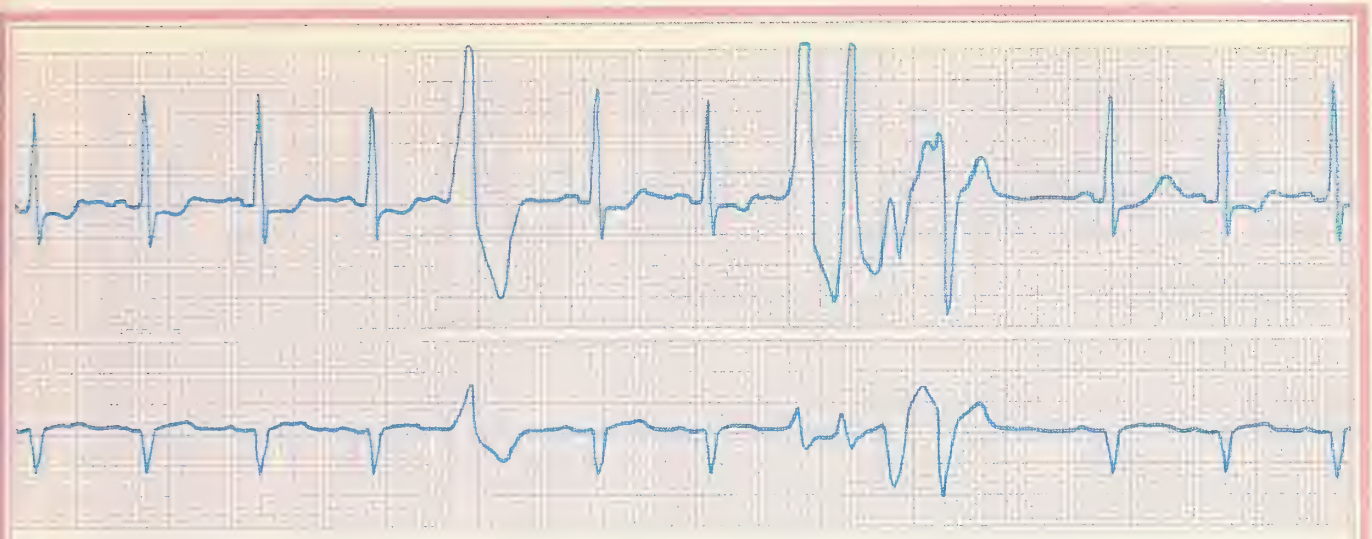
1. Abolishes the position of the PMS Secretary and provides for the election of a secretary from the Board of Trustees, as recommended by the Special Committee to Study the Makeup of the PMS Board.

Chapter XIII—Officers

Section 3. Terms of Office . . .
e. A secretary shall serve from the [conclusion of the annual meeting of the House of Delegates at which elected until the next annual meeting at which a successor is elected.] *reorganization meeting of the Board of Trustees of the annual meeting at which elected by the Board of Trustees until the next reorganization meeting.*

Chapter XV—The Board of Trustees

Section 10. Board Officers—At the first meeting of the Board of Trustees after the annual meeting of the House of Delegates, it shall elect, from among the district trustees, a chairman, [and] a vice chairman, *and a secretary* to serve until the next such meeting of the Board and until their successors are elected . . .
The secretary of [this Society] *the Board of Trustees* shall serve as secretary of the [Board of Trustees.] *Society.*



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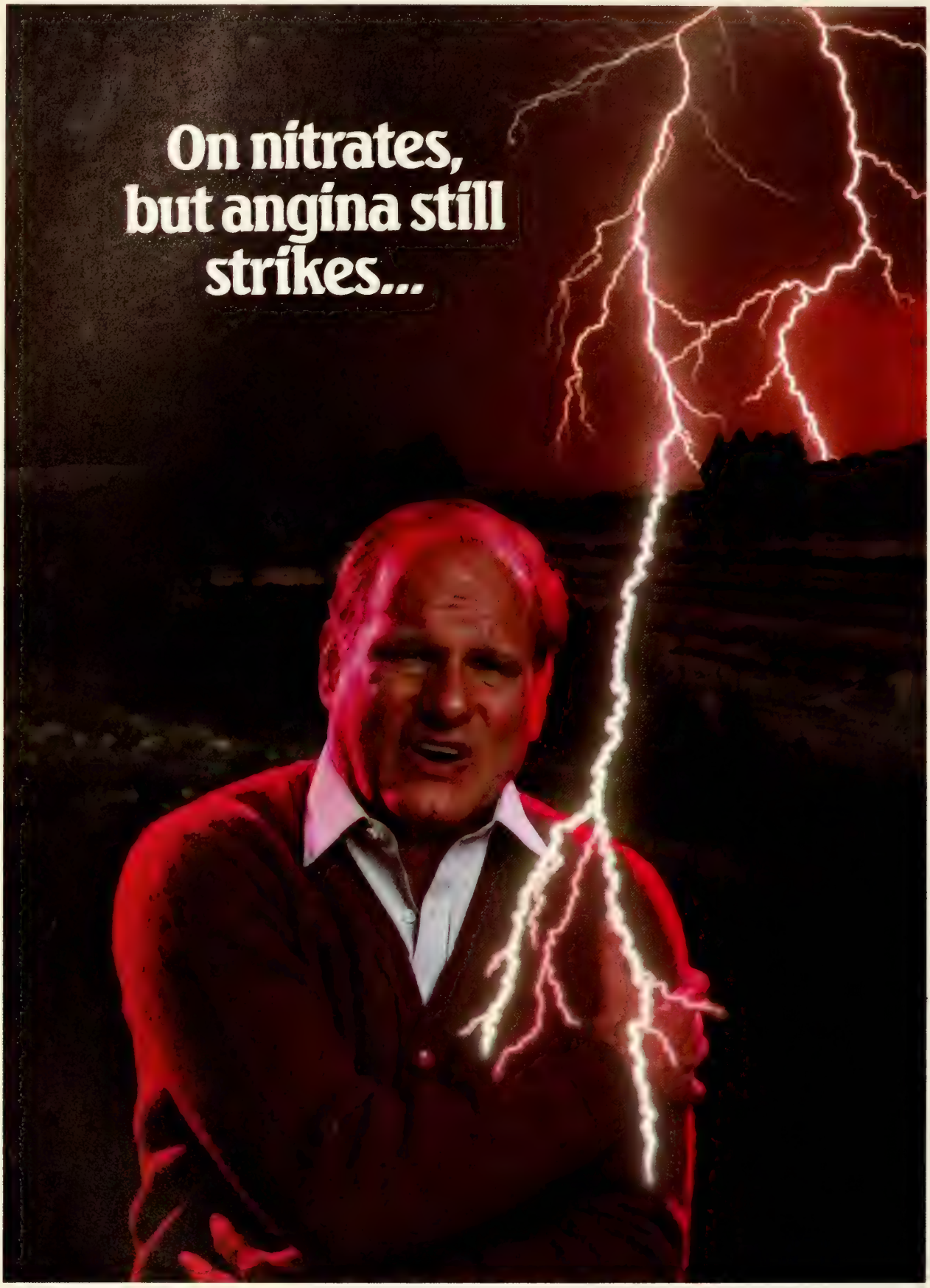
On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
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To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

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With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

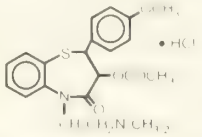
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic	Pruritus, petechiae, urticaria, photosensitivity.
Other	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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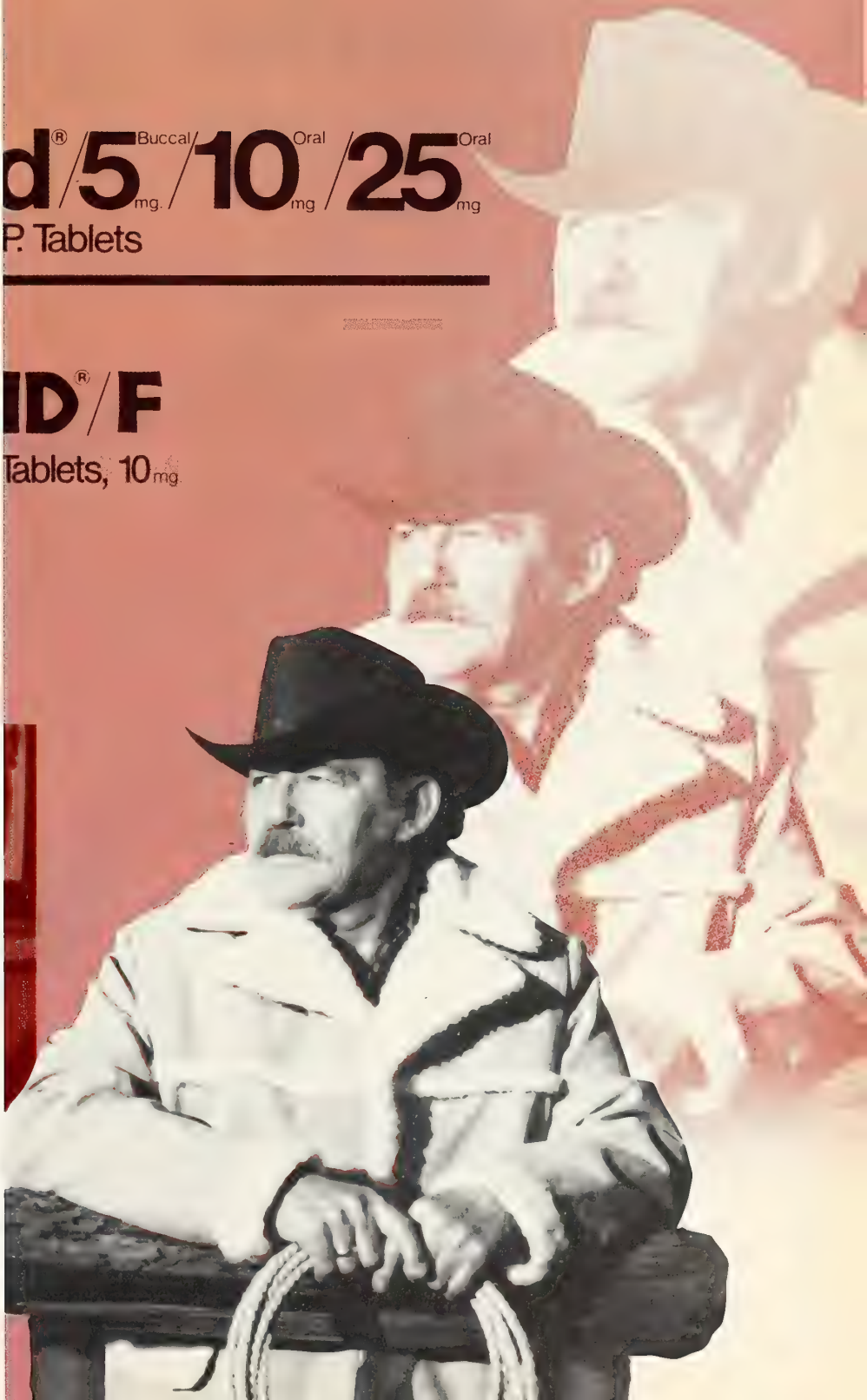
d®/5 Buccal mg./10 Oral mg/25 Oral mg
P. Tablets

ID®/F
Tablets, 10 mg

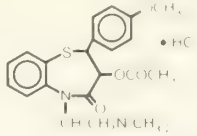


PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%),

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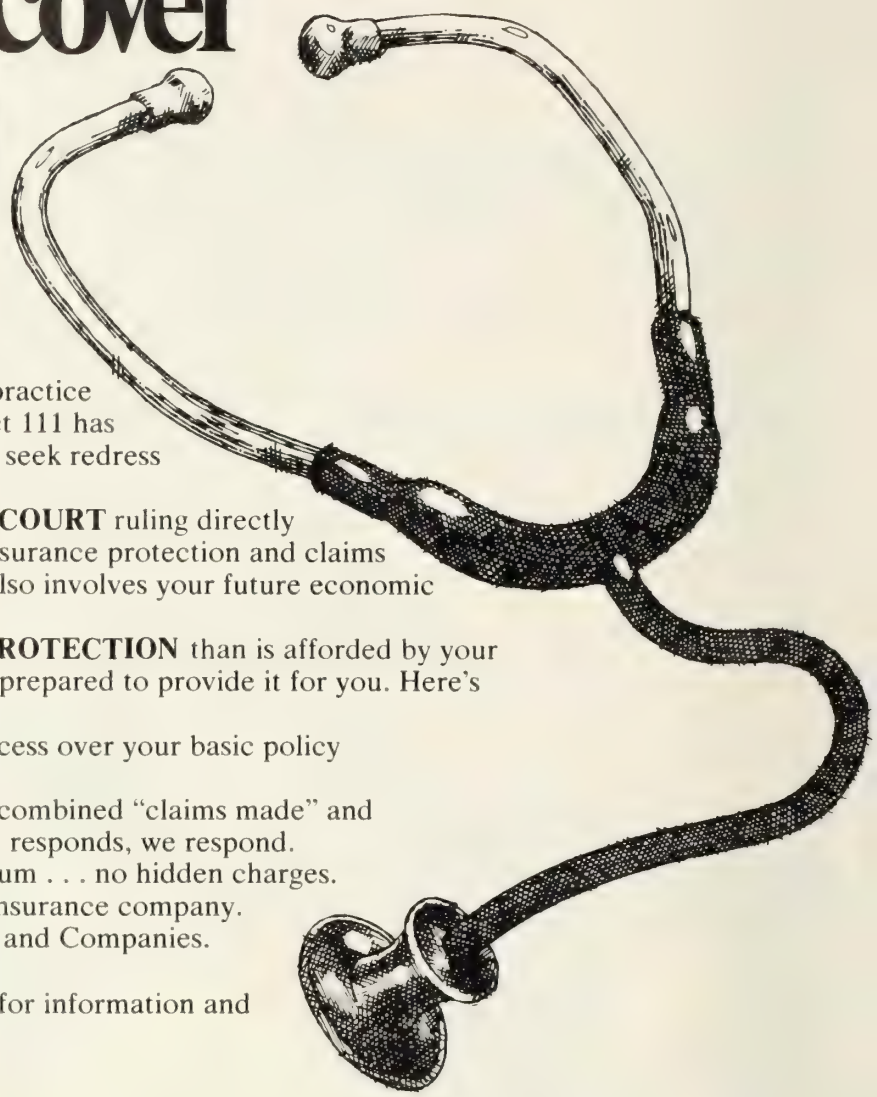

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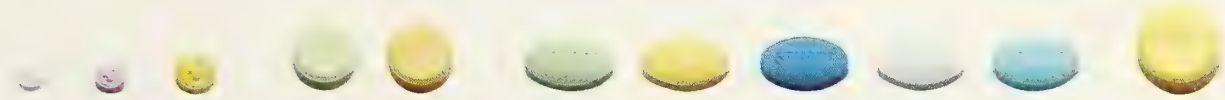

2.5 mg 5 mg 10 mg — Sublingual Tablets

5 mg 10 mg — Chewable Tablets

5 mg 10 mg 20 mg 30 mg 40 mg — Oral "Swallow" Tablets

40 mg — Sustained Action "Swallow" Tablets

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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg, for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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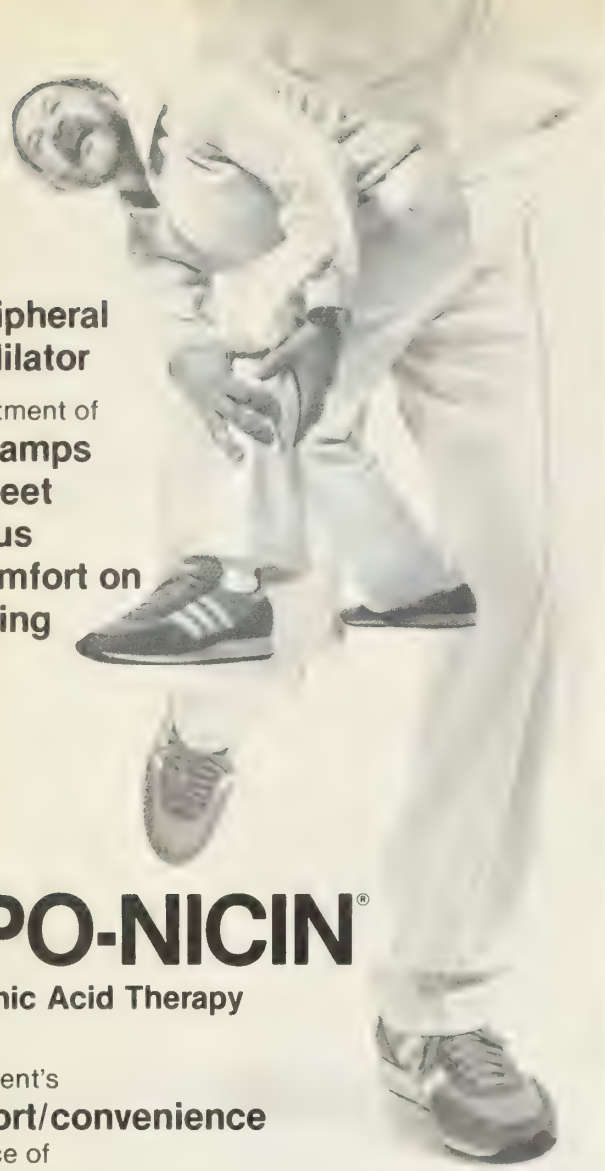

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Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding

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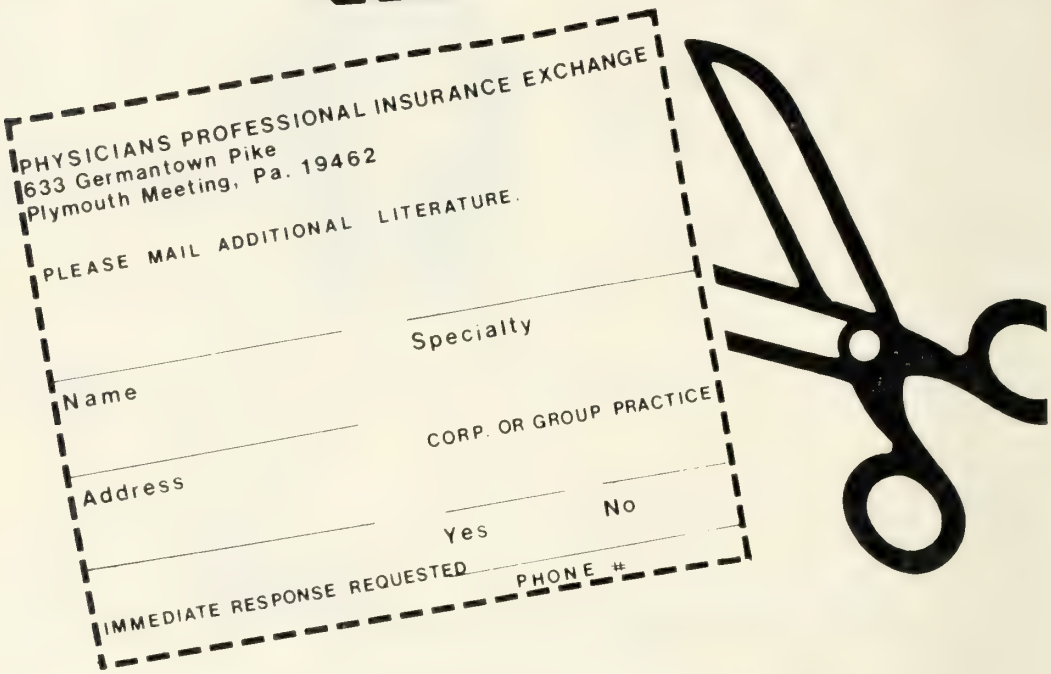

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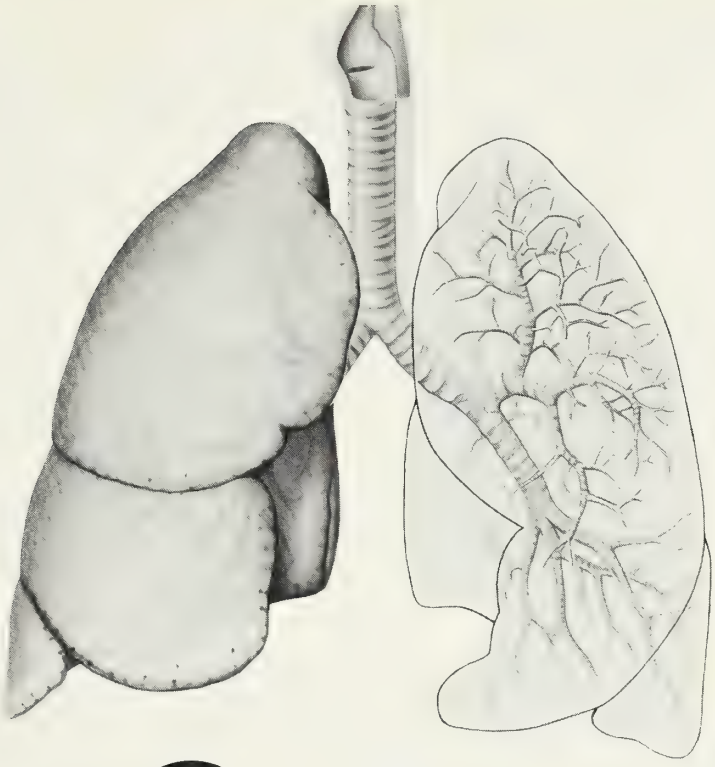
Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, H. influenzae, S. pneumoniae, S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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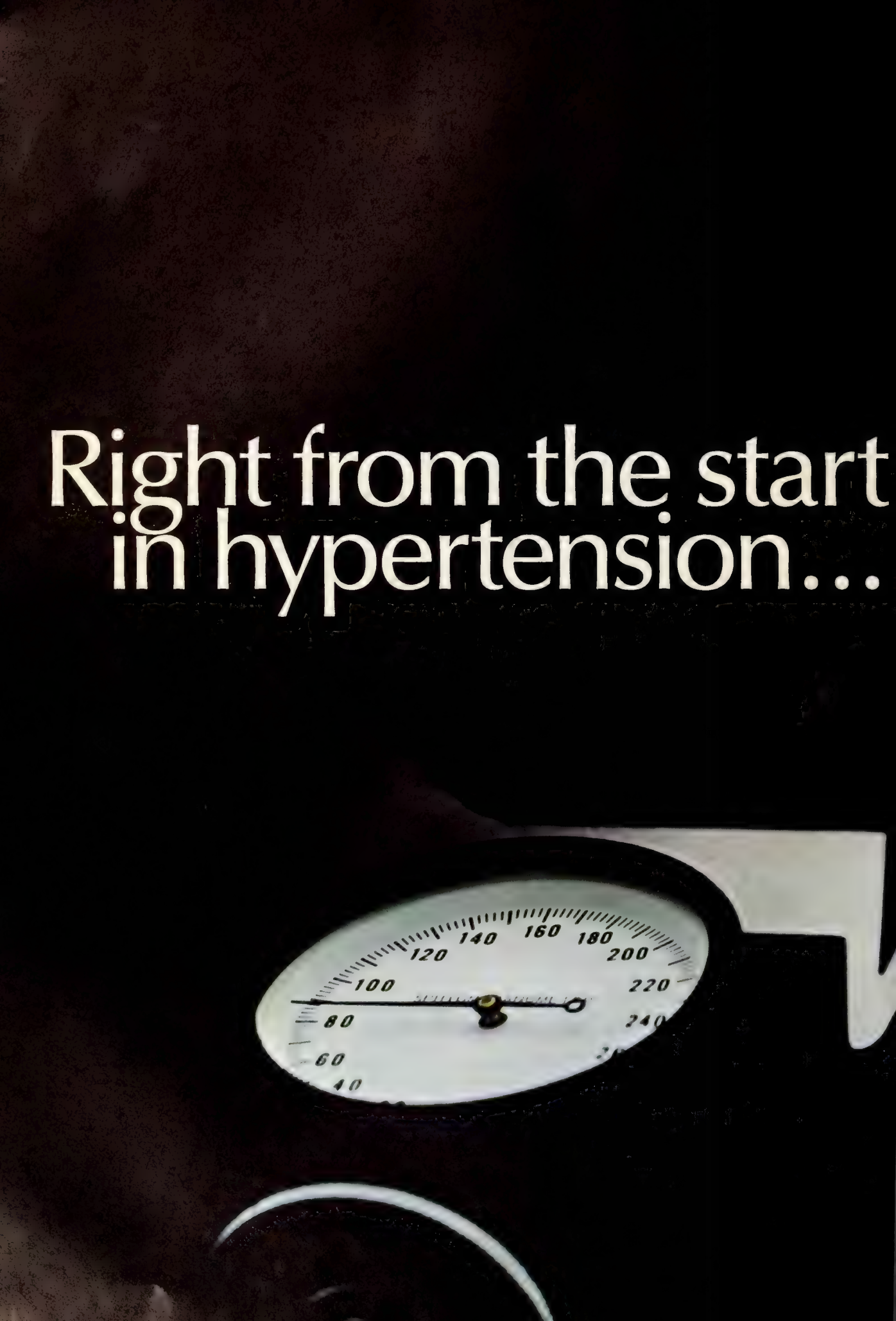

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Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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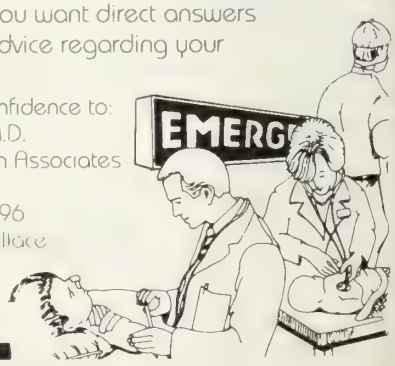

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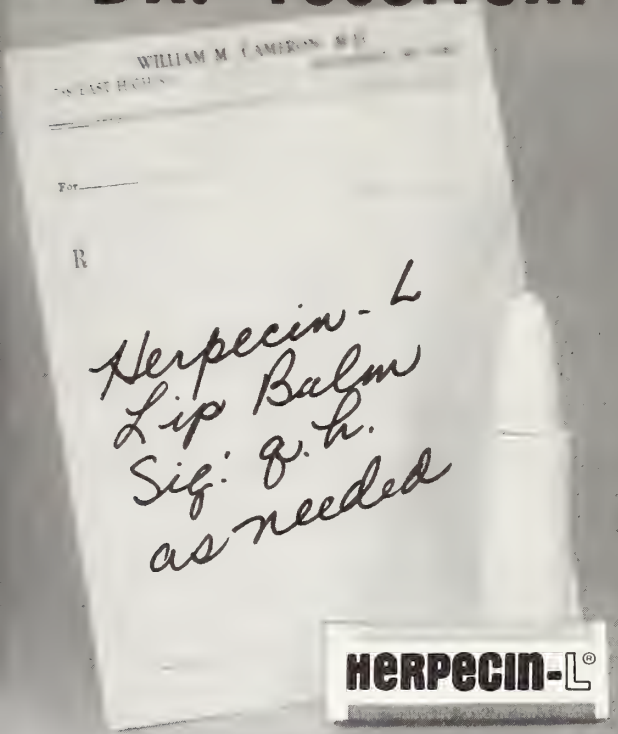

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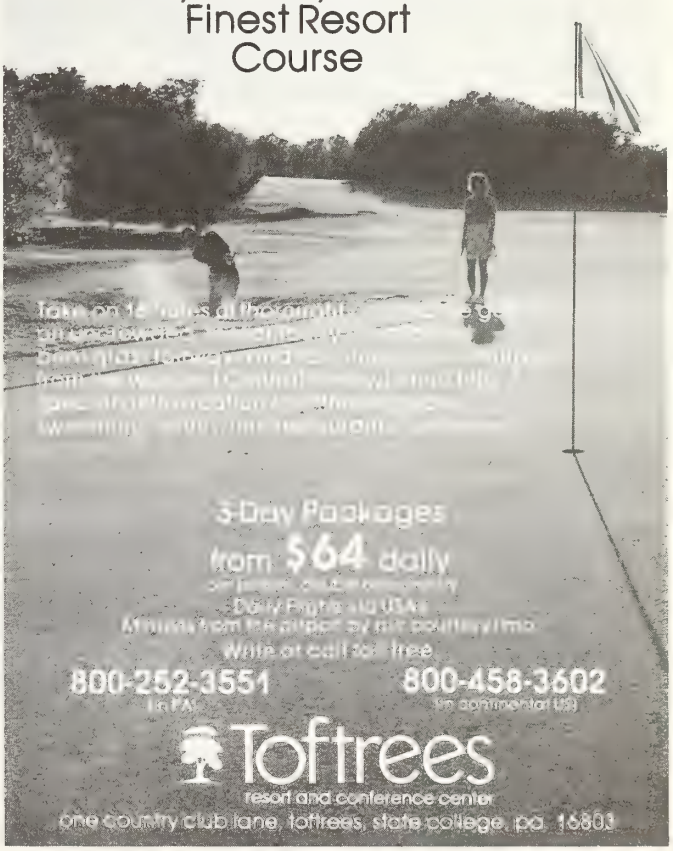

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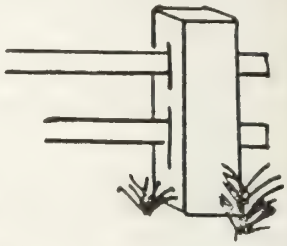

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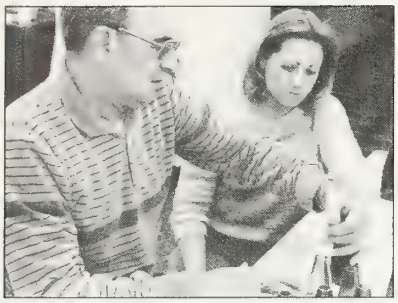
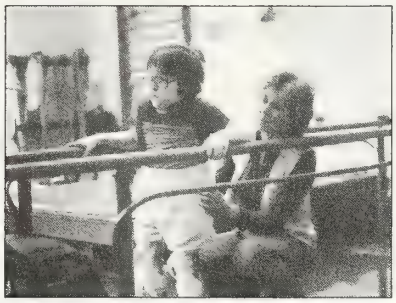
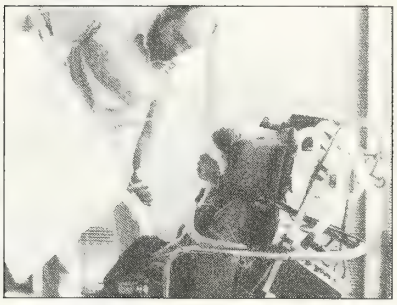

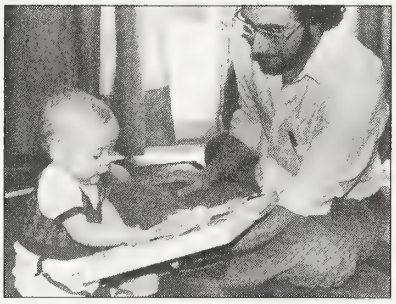
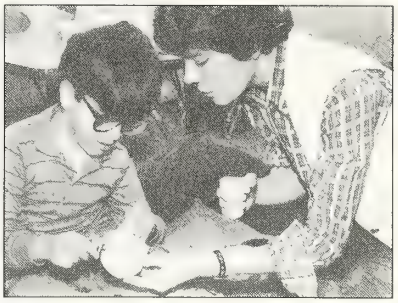

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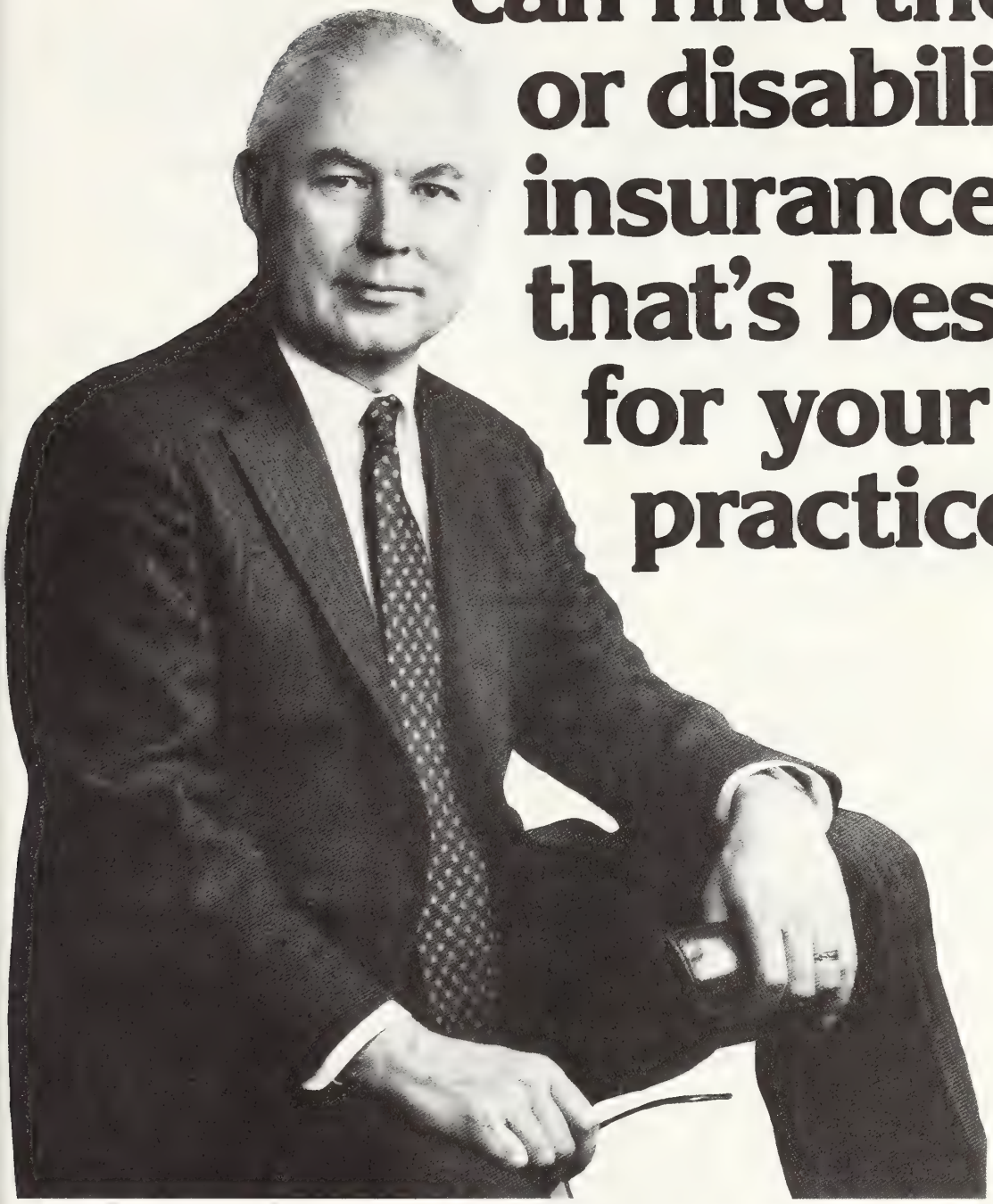

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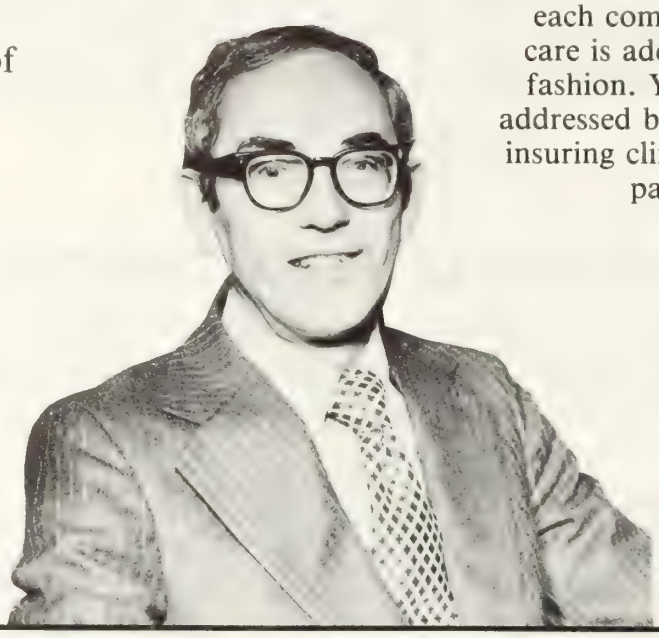

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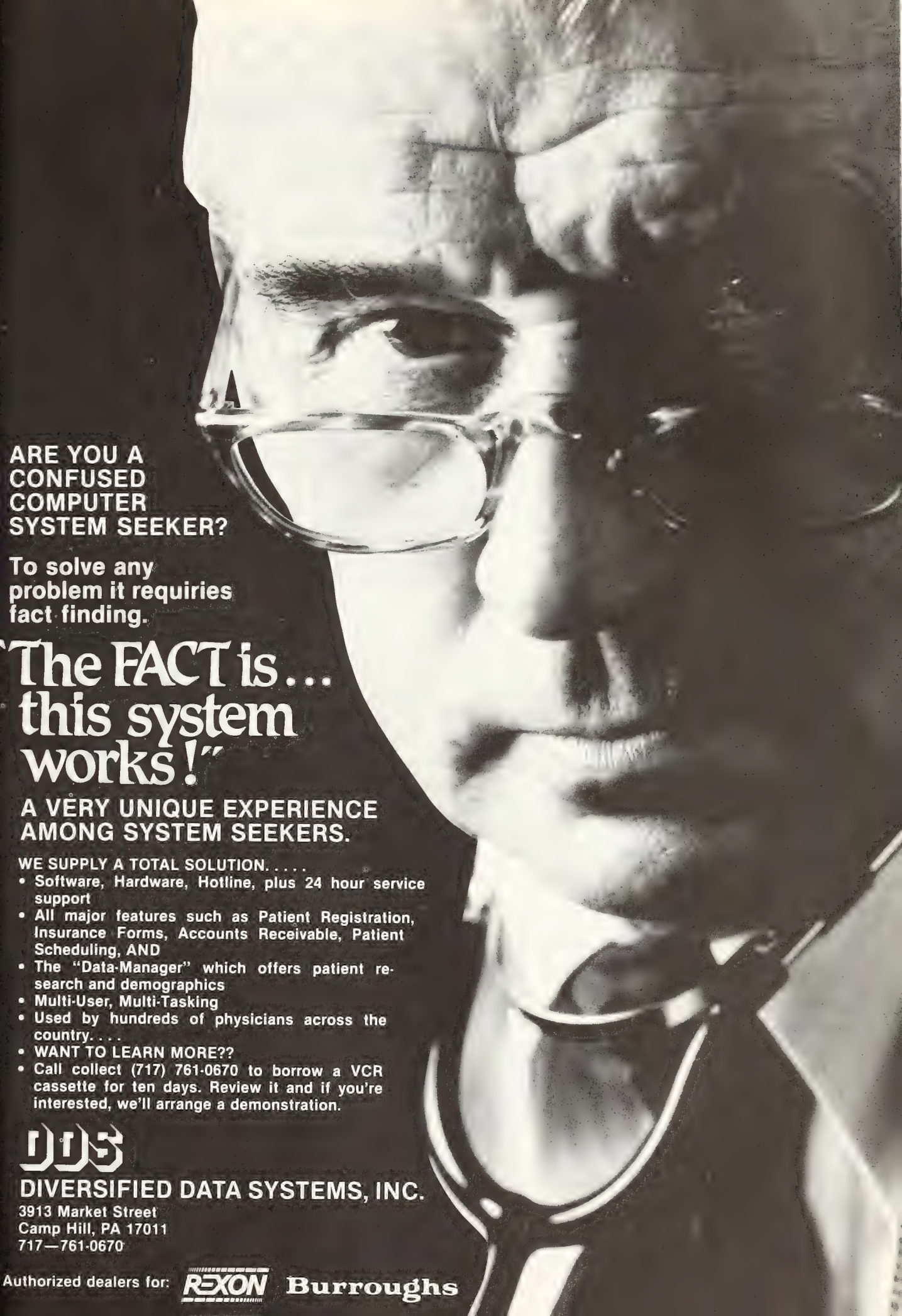
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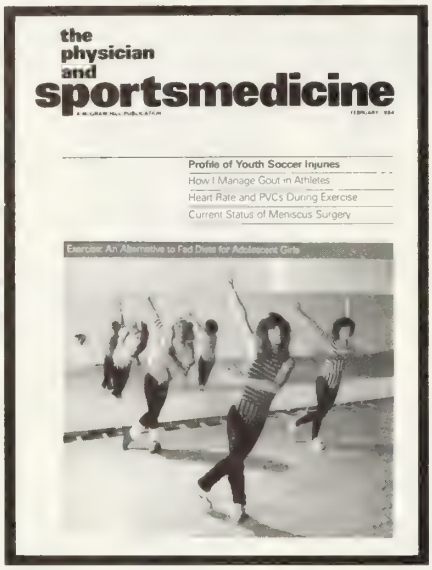

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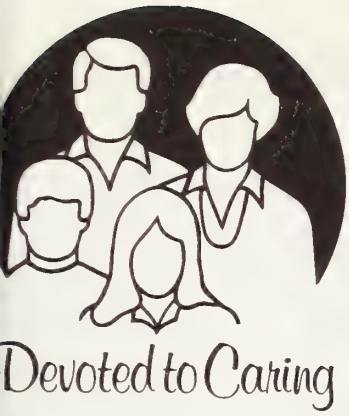

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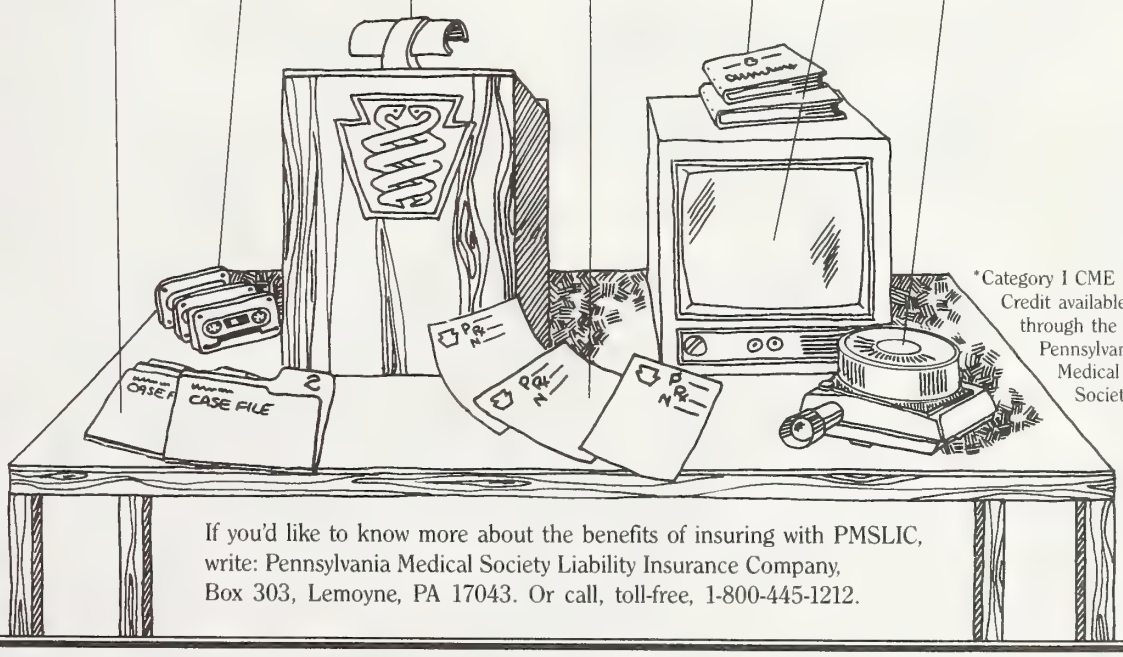

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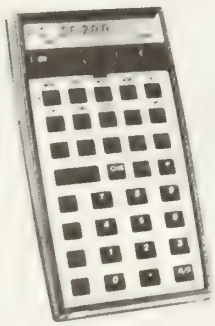

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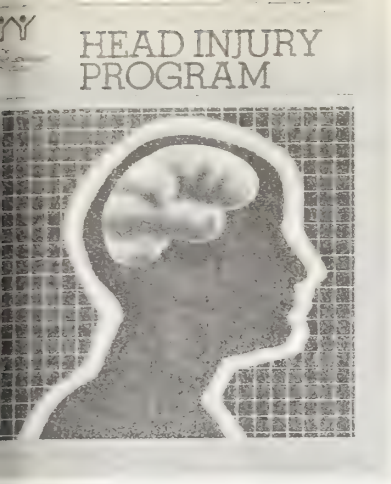

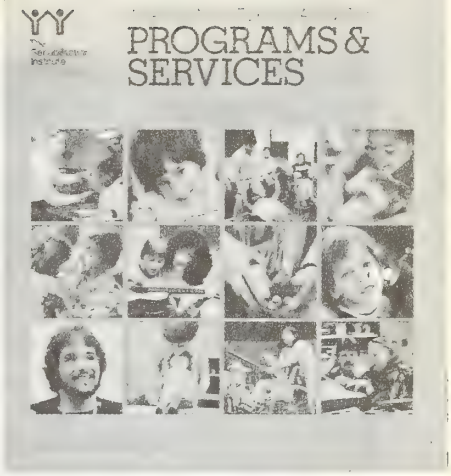

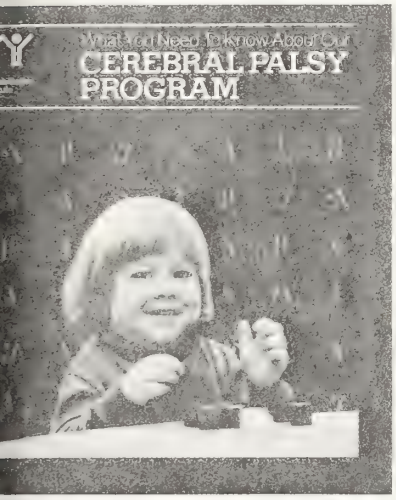

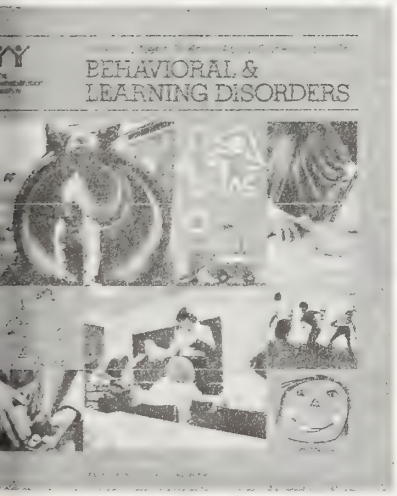

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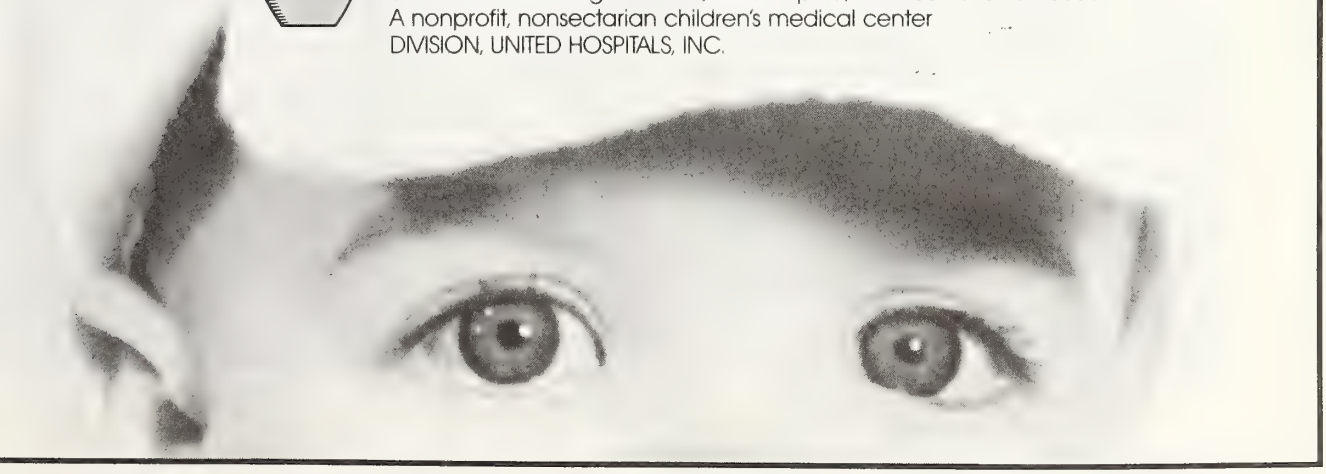

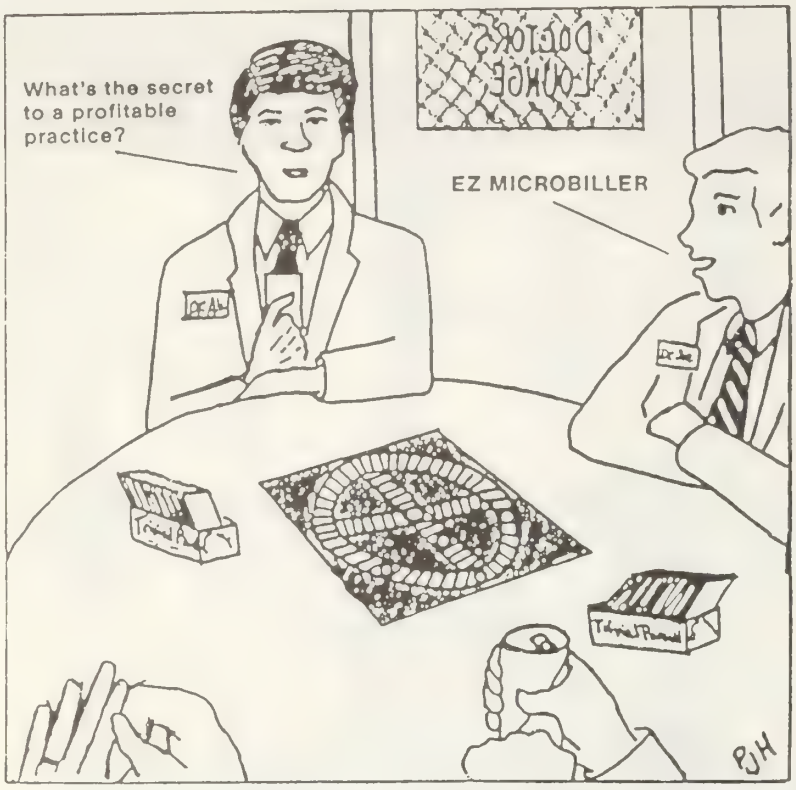

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ADL	Adolescent Medicine	2
AI	Allergy and Immunology	33
AM	Aerospace Medicine	5
A	Allergy	67
AN	Anesthesiology	663
BE	Broncho-Esophagology	2
BLB	Bloodbanking	0
CD	Cardiovascular Diseases	515
D	Dermatology	227
DMP	Dermatopathology	2
DIA	Diabetes	26
EM	Emergency Medicine	354
END	Endocrinology	65
FP	Family Practice	1,484
GE	Gastroenterology	202
GP	General Practice	1,310
GPM	General Preventive Medicine	12
GER	Geriatrics	32
GYN	Gynecology	70
HEM	Hematology	66
HYP	Hypnosis	1
IG	Immunology	5
ID	Infectious Diseases	38
IM	Internal Medicine	2,110
LAR	Laryngology	1
LM	Legal Medicine	4
MFS	Maxillofacial Surgery	0
ND	Neoplastic Diseases	16
NEP	Nephrology	87
N	Neurology	182
NPM	Neonatal-Perinatal Medicine	10
CHN	Neurology, Child	4
NA	Neuropathology	2
NM	Nuclear Medicine	53
NR	Nuclear Radiology	1
NTR	Nutrition	3
OBS	Obstetrics	5
OBG	Obstetrics/Gynecology	1,014
OM	Occupational Medicine	110
ON	Oncology	104
OPH	Ophthalmology	617
OT	Otology	4
OTO	Otolaryngology	308
PTH	Pathology	332
CLP	Pathology, Clinical	35
FOP	Pathology, Forensic	3
PD	Pediatrics	647
PDA	Pediatrics, Allergy	18
PDC	Pediatrics, Cardiology	10
PDE	Pediatric Endocrinology	0
PHO	Pediatric Hematology-Oncology	2
PNP	Pediatric Nephrology	1
PA	Pharmacology, Clinical	24
PM	Physical Medicine/Rehabilitation	176
P	Psychiatry	635
CHP	Psychiatry, Child	67
PYA	Psychoanalysis	31
PYM	Psychosomatic Medicine	5
PH	Public Health	26
PUD	Pulmonary Diseases	159
R	Radiology	458
DR	Radiology, Diagnostic	363
PDR	Radiology, Pediatric	10
TR	Radiology, Therapeutic	72
RHU	Rheumatology	90
RHI	Rhinology	0
RIP	Radioisotopic Pathology	0
ABS	Surgery, Abdominal	14
CDS	Surgery, Cardiovascular	106
CRS	Surgery, Colon and Rectal	49
GS	Surgery, General	1,152
HS	Surgery, Hand	14
HNS	Surgery, Head and Neck	5
NS	Surgery, Neurological	150
ORS	Surgery, Orthopaedic	606
PDS	Surgery, Pediatric	21
PS	Surgery, Plastic	139
TS	Surgery, Thoracic	103
TRS	Surgery, Traumatic	5
U	Surgery, Urological	366
OS	Other, i.e., physician designated a specialty other than those appearing above, including 303 students.	868
	Total Membership	16,578

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*1853	John P. Heister, MD	Berks County
*1854	Jacob M. Gimmill, M.D.	Huntingdon County
*1855	James S. Carpenter, M.D.	Schuylkill County
*1856	Rene La Roche, M.D.	Philadelphia County
*1857	John L. Atlee, M.D.	Lancaster County
*1858	Smith Cunningham, M.D.	Beaver County
*1859	D. Francis Condie, M.D.	Philadelphia County
*1860-61	Edward Wallace, M.D.	Berks County
*1862	George F. Horton, M.D.	Bradford County
*1863	Wilson Jewell, M.D.	Philadelphia County
*1864	J.D. Ross, M.D.	Blair County
*1865	William Anderson, M.D.	Indiana County
*1866	James King, M.D.	Allegheny County
*1867	Traill Green, M.D.	Northampton County
*1868	John Curwen, M.D.	Dauphin County
*1869	William M. Wallace, M.D.	Erie County
*1870	Samuel D. Gross, M.D.	Philadelphia County
*1871	J.S. Crawford, M.D.	Lycoming County
*1872	A.M. Pollock, M.D.	Allegheny County
*1873	S.B. Kiefer, M.D.	Cumberland County
*1874	Washington L. Atlee, M.D.	Philadelphia County
*1875	Crawford Irwin, M.D.	Blair County
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*1881	Jacob L. Zeigler, M.D.	Lancaster County
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*1883	Henry H. Smith, M.D.	Philadelphia County
*1884	Ezra P. Allen, M.D.	Bradford County
*1885	E.A. Wood, M.D.	Allegheny County
*1886	Rees Davis, M.D.	Luzerne County
*1887	Richard J. Levis, M.D.	Philadelphia County
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*1890	Alexander Craig, M.D.	Lancaster County
*1891	Samuel L. Kurtz, M.D.	Berks County
*1892	Henry L. Orth, M.D.	Dauphin County
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*1894	John B. Roberts, M.D.	Philadelphia County
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*1902	William M. Welch, M.D.	Philadelphia County
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*1904	Adolph Koenig, M.D.	Allegheny County
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P O Box 650
Bedford PA 15222
MAYLOCK, MD, John H PTH
Bedford Memorial Hosp Rte 1
Everett PA 15537
MCCAHAN, MD, Wesley F GP
39 N Spring St
Everett PA 15537
NEWMAN, MD, William R R
300 S Juliana St
Bedford PA 15522
PALIN, MD, William E GS
P O Box 637
Bedford PA 15522
POMPILIO, MD, Kenneth J OPH
Pennwood Rd
Everett PA 15537
RINARD, MD, Graffious L GP
345 E John St
Bedford PA 15522
TORRES, MD, Flora M FP
220 W Main Street
Everett PA 15537
TORRES, MD, Robin G OBG
220 W Main
Everett PA 15537
TOUSI, MD, Abbas H OBG
400 Oakwood Drive
Bedford PA 15522
WHITMORE, MD, John T IM
P O Box 3175
Lavale MD 21502

BERKS

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1544 Rose Virginia Rd
Wyomissing PA 19610
AITA, MD, Paul C GS
301 S Seventh Ave
West Reading PA 19611
ALEXANDER, MD, Marcia L R
450 Warwick Dr
Wyomissing Hills PA 19610
ALEXANDER, MD, R William R
544 Elm St
Reading PA 19601
ALLEY, MD, Samie A GS
1146 Elm St
Reading PA 19604
ANDERSON, MD, John B OBG
1340 W Penn Ave
Wyomissing PA 19610
ARNDT, MD, James L P
Wissahickon Garden Apts 4-D
Philadelphia PA 19144
ASHIZAWA, MD, James H FP
200 N 13th St Ste 100
Reading PA 19604
ASHWORTH, MD, Halbert E TS
1235 Penn Avenue
Wyomissing PA 19610
AURANDT, MD, Henry N OBG
301 S 7th Ave
West Reading PA 19611
AVELLA, MD, Bernard N IM
301 S Seventh Ave
West Reading PA 19611
AYNARDI, MD, J Marc IM
Rt 422 & Airport Road
Douglasville PA 19518
BANEY JR, MD, Charles M FP
P O Box 169 260 State St
Hamburg PA 19526
BARRETT, MD, John S CD
301 S Seventh Ave
West Reading PA 19611
BARRIOS, MD, Mario F FP
35 Madison Avenue
Reading PA 19605
BECKER, MD, Ward G FP
404 Fairview Dr
Kutztown PA 19530
BEEM, MD, John W OPH
R D 3081
Mohnton PA 19540
BEETEL, MD, Christopher J GS
301 S Seventh Ave
West Reading PA 19611
BELL, MD, Richard T PUD
301 S Seventh Ave
West Reading PA 19611
BERMAN, MD, Arnold M FP
R D 3 Box 3727
Reading PA 19606
BERTOLET, MD, Charles B GP
39 N 23rd St
Reading PA 19606
BERTOLETTE, MD, Richard D P
810 Kenhorst Blvd
Reading PA 19611
BIALAS, MD, Henry N US
727 Penn Ave
West Reading PA 19611
BIGOS, MD, Edward T FP
2339 Spring Street
West Lawn PA 19609
BISBING, MD, John H PUD
1020 Reading Blvd
Wyomissing PA 19610
BITETTO, MD, Nicola CD
200 N 13th St
Reading PA 19604
BLAUSER, MD, Robert B FP
260 State Street
Hamburg PA 19526
BOEHMLER, MD, William J P
St Joseph Hosp Box 316
Reading PA 19603
BOHNENBLUST JR, MD, IM
Walter R
512 Stephen Rd
Reading PA 19601
BONACCORSI, MD, Diane T FP
Rt 10 Park Road Plaza
Reading PA 19607
BONNER, MD, Mary J IM
816 Holland Sq
Wyomissing PA 19610
BOWER, MD, John R OBG
1340 Penn Ave
Wyomissing PA 19610
BOWER, MD, John Roebrich P
840 Centre Ave
Reading PA 19601
BRACKBILL, MD, Elizabeth J GP
810 Farr Place
Reading PA 19611
BRACKBILL, MD, Robert M IM
215 N Sixth St
Reading PA 19601
BRUBAKER, MD, Elwood R OBG
301 S 7th Ave
West Reading PA 19611
BRZOZOWSKI, MD, Lawrence A R
200 N 13th St
Reading PA 19604
BUB, MD, Barry FP
1800 Hampden Blvd
Reading PA 19604
BUCH, MD, Sandhya Y FP
Community Gen Hosp
Reading PA 19603
BULATAO, MD, Agapito V GS
Communtiy General Hospital
Reading PA 19601
BURNS, MD, Donald T OPH
1500 Penn Ave
Wyomissing PA 19610
BUSH, MD, William M GYN
1830 Oak Ln
Reading PA 19604
BUTTERWORTH, MD, Thomas D
411 Walnut St
Reading PA 19601
BUZAS, MD, Jerome W D
2650 Westview Drive
Wyomissing Hills PA 19610
CALATA, MD, Eliseo R PM
Reading Rehabilitation Hos
Reading PA 19607
CALLAHAN, MD, Charles M PD
130 Prospect St
Reading PA 19606
CANNER, MD, Gary C ORS
1150 Berkshire Blvd
Wyomissing PA 19610
CAPPA, MD, Robert J FP
R D 2 Box 323-A
Oley PA 19547
CARABELLO, MD, Charles A PD
316 S Fifth St
Reading PA 19602
CARIM, MD, Hyder M PD
1981 Bern Rd
Wyomissing PA 19610
CARIM, MD, Moiz M OPH
56 Nassau Circle
Flying Hills PA 19607
CARLSON, MD, Stephen E GE
606 Court St
Reading PA 19601
CATLIN, MD, Robin J O FP
301 S Seventh Ave
West Reading PA 19611
CEFARATTI, MD, Michael D OPH
606 Count St Ste 200
Reading PA 19601
CHANG, MD, Myunghwan AN
Sanit Joseph Hospital
Reading PA 19603
CHELIUS, MD, Alan B FP
536 Franklin St
Reading PA 19602
CHENSEE, MD, Jasper G PTH
2147 Perkiomen Ave
Mount Penn PA 19606
CHETT, MD, Nicholas J GP
203 Noble St
Shoemakersville PA 19555
CHIRIELEISON, MD, Rocco F IM
301 S Seventh Ave
West Reading PA 19611
CHOWDHURY, MD, A Rab GE
8 N 11th St
Reading PA 19601
CHRIST, MD, Nicholas J GP
141 N Walnut St
Birdsboro PA 19508
CHRISTENSEN, MD, David W GP
301 S Seventh Ave
West Reading PA 19611
CINELLI, MD, Cleto G OS
200 N 13th St Ste 105
Reading PA 19604
CITRO, MD, Laurence A DR
520 Lauers Ln
Reading PA 19610
CLEMENTS, MD, William T FP
260 E Washington
Wernersville PA 19565
CLOSE, MD, Richard NS
601 Spruce St
West Reading PA 19611
CLYMER, MD, Robert H U
301 S Seventh Ave
West Reading PA 19611
COHEN, MD, Bruce A FP
337 W Main St
Birdsboro MD 19508
COHN, MD, C Harold TS
301 S Seventh Ave
West Reading PA 19611
COMESS, MD, Raymond R GS
200 N 13th St #204
Reading PA 19604
CONNERTON, MD, George E PTH
R D 3 Box 154-A
Mohnton PA 19540
COPE, MD, David A OTO
301 S Seventh Ave
West Reading PA 19611
CRAIG, MD, Paul C OPH
Pennswood Village D-113
Newtown PA 18940
CRAMP, MD, Lloyd L GS
15 E Congressional Circle
Reading PA 19607
CRUTCHER, MD, James E FP
200 N 13th St Ste 100
Reading PA 19604
CRYSTAL, MD, Harry GP
715 Old Mill Rd E-1
Reading PA 19610
DAIELLO, MD, David C IM
11-A Flying Hills Village
Reading PA 19607
DALY, MD, David G IM
520 Douglass St
Wyomissing PA 19610
DASHE, MD, Myer M GP
606 N 10th St
Reading PA 19604
DAVIS, MD, William B FP
200 N 13th Street
Reading PA 19603
DEBENEDICTIS, MD, Kenneth J A
600 Museum Rd
Reading PA 19611
DEGUZMAN, MD, Rudolfo L EM
St Joseph Hosp
Reading PA 19603
DEIBERT, MD, David C IM
301 S Seventh Avenue Ste 345
West Reading PA 19611
DELENICK, MD, Peter J ORS
210 N Sixth St
Reading PA 19601
DELVECCHIO, MD, Leonard M FP
E 1St & Spruce Sts
Birdsboro PA 19508
DENBY, MD, Robert A GP
25 Stevens Ave
West Lawn PA 19609
DENGLER, MD, Ernest H OPH
713 N Fifth St
Reading PA 19601
DERR, MD, Craig A IM
24 Sandy Way
Reading PA 19607
DERSH, MD, Jerome OPH
606 Court St Ste 200
Reading PA 19601
DESANCTIS JR, MD, Joseph J IM
606 Museum Rd
Reading PA 19611
DESJARDINS, MD, George P PTH
504 Carsonia Avenue
Reading PA 19606
DESJARDINS JR, MD, George P EM
Saint Joseph Hospital
Reading PA 19603
DETHOFF, MD, John C ORS
1512 N 15th Street
Reading PA 19604
DIETRICH, DO, Leonard M US
610 E Main St Box 243
Kutztown PA 19530
DIRENZO, MD, Dennis P PD
105 Wyoming Road
Wyomissing PA 19610
DONLY, MD, Donovan L GP
232 N Fifth St
Reading PA 19601
DONNELLY JR, MD, Joseph C CDS
200 N 13th Street Suite 207
Reading PA 19604
DONOVAN, MD, Robert S FP
R D 8050
Sinking Spring PA 19608
DREAZEN, MD, Jonathan R FP
270 Friedensburg Road
Reading PA 19606
DUDA, MD, Andrew M TS
301 S Seventh Ave
West Reading PA 19611
DUFFY, MD, Scott S IM
301 S Seventh Ave
West Reading PA 19611
EAGER, MD, J Michael OBG
1340 Penn Ave
Wyomissing PA 19610
EASTLAND, MD, Theodore W GP
407 W Vine St
Fleetwood PA 19522
EBERSOLE, MD, Thomas M OBG
601 Penn St Ste 1000
Reading PA 19601
EDMUNDS, MD, Elizabeth H FP
2001 Steuben Road
Reading PA 19602
EISENBERG, MD, H Grant OBG
310 Lynoak Ave
Shillington PA 19607
EMKEY, MD, Kenneth D GE
301 S Seventh Ave Ste 330
West Reading PA 19611
EMKEY, MD, Ronald D RHU
401 Buttonwood St
West Reading PA 19611
ERICKSEN, MD, Arthur N GP
1836 Salem Road
Reading PA 19610
ERMOLD, MD, Donald R GP
425 E Lancaster Ave
Shillington PA 19607
FALLON III, MD, Edward C DR
Reading Hosp
Reading PA 19603
FARBER, MD, David N OPH
606 Court St Ste 200
Reading PA 19601
FARBER, MD, Eric B OPH
R D 1 Eight Hessian Blvd
Reading PA 19607
FARBER, MD, Harold I IM
308 N Fifth St
Reading PA 19601
FAUST, MD, Donald S TR
The Reading Hosp & Med Ct
Reading PA 19603
FEASTER, MD, Marshall M CDS
1235 Penn Ave
Wyomissing PA 19610
FEHNEL, MD, Stephen H OBG
301 S Seventh Ave
West Reading PA 19611
FEICK, MD, Ralph H GP
807 N 10th St
Reading PA 19604
FERRY, MD, Gerald W OBG
200 N 13th St
Reading PA 19604
FISCHER, MD, Edward C F
The Reading Hosp
Reading PA 19603
FLEISCHER, MD, Alan N U
200 N 13th Street
Reading PA 19603
FLORES, MD, Evelyn R N
200 N 13th St
Reading PA 19604
FOLDES-ROTH, MD, Elisabeth GYN
105 S Fifth St
Reading PA 19602
FRANCOIS, MD, Max B AN
2021 Franklin Place
Wyomissing PA 17610
FRANGIPANE, MD, Leo G GS
301 S Seventh Avenue
West Reading PA 19611
FRANK, MD, Jeffrey B OBG
301 S Seventh Ave
West Reading PA 19611
FRANTZ, MD, Robert C ON
532 Park Rd
Wyomissing PA 19610
FRIEDMAN, MD, Ellis F ORS
2130 Penn Ave
West Lawn PA 19609
FUSCO-RIPKA, MD, Giovanna D OS
1216 Meade St
Reading PA 19611
GABLE, MD, Joseph E GP
2129 N 17th St
Reading PA 19604
GALLEN, MD, John H GN
2950 Van Reed Rd
Sinking Spring PA 19608
GARCIA, MD, Antonio S OS
Box 185
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38 E Lancaster Ave
Shillington PA 19607
GEHRIS, MD, Leroy A FP
808 N Third St
Reading PA 19601
GEORGE, MD, David L IM
401 Buttonwood St
W Reading PA 19611
GEORGE, MD, Paula PD
1258 Penn Ave
Wyomissing PA 19610
GERHART, MD, George R FP
3351 Perkiomen Ave
Reading PA 19606
GIACCIA, MD, Amato GP
600 Schuylkill Ave
Reading PA 19601
GIESECKE, MD, Susan B DR
7 Iron Cir Flying Hills
Reading PA 19607
GILFILLAN, MD, A George PD
1981 Bern Rd
Wyomissing PA 19610
GILMORE, MD, Irvin W GP
5313 Allentown Pike
Temple PA 19560
GLOSSER, MD, William E EM
1240 Dauphin Ave
Wyomissing PA 19610
GOODMAN, MD, Gerald A R
1305 Old Mill Rd
Wyomissing PA 19610
GORAN, MD, Daniel D GS
150 N 11th Street
Reading PA 19601
GORDON, MD, Michael E R
91 Grandview Blvd
Wyomissing Hills PA 19609
GOUGER, MD, Dale B P
301 S Seventh Ave
West Reading PA 19611
GRABIAS, MD, Stanley L ORS
606 Museum Rd
Reading PA 19611
GRAHAM, MD, Barry E OBG
1340 Penn Ave
Wyomissing PA 19610
GRANADOS, MD, Nicanor G IM
1555 Schuylkill Ave
Reading PA 19601
GRANADOS, MD, Suzita N PD
130 Prospect Street
Reading PA 19606
GRAUBARD, MD, Howard M FP
200 N 13th St
Reading PA 19603
GREENBERG, MD, Robert N GS
200 N 13th Suite 204
Reading PA 19604
GREENE, MD, Lucille T GP
412 N 12th St
Reading PA 19604
GREGORY, MD, George W CDS
1235 Penn Avenue
Wyomissing PA 19610
GRETH, MD, Warren E RHU
401 Buttonwood St
West Reading PA 19611
GRIM, MD, Mark D GP
Main St
Oley PA 19547
GROH, MD, William C IM
200 N 13th St
Reading PA 19604
GROSS, MD, Lawrence S PD
609 Walnut St
Reading PA 19601
GRUBB, MD, Willard Y FP
Route 100
Bally PA 19503
GRUBER, MD, John W CD
301 S 7th Ave
West Reading PA 19611
GANGEN, MD, Norman M GP
4 Allison Rd Greenfields
Reading PA 19601
GANJURA, MD, Girdhari L ON
120 Prospect St
Reading PA 19606
GANNA, MD, Ezzat A FP
600 High Blvd
Reading PA 19607
HARRIS, MD, Lawrence K CD
Community Gen Hosp
Reading PA 19601
HASSAN, MD, Joseph R IM
4201 Kutztown Road
Temple PA 19560
HASSEL, MD, Jeffrey L IM
215 N Sixth St
Reading PA 19601
HASSEL, MD, Patricia A IM
2005 Cypress Lane
Wyomissing PA 19610
HAUSER, MD, Raymond J FP
Arrowhead
Bowers PA 19511
HEFFERNAN, MD, John M IM
2001 Bern Road
Wyomissing PA 19610

HEINBACH, MD, Wilfred F IM
P O Box 88
Oley PA 19547
HEISEY, MD, John C IM
39 Thomas Oaks Dr
Pottstown PA 19464
HELLER, MD, Fredericka S M OBG
939 Penn Avenue
Wyomissing PA 19610
HENNINGER, MD, William H AN
189 Oakmont Dr
Reading PA 19607
HERMANOVICH JR, MD, John CD
301 S Seventh Ave Ste 235
West Reading PA 19611
HEY JR, MD, E Berry CD
301 S Seventh Ave
West Reading PA 19611
HIEHLE, MD, John F R
The Reading Hosp
Reading PA 19603
HIGH, MD, Bertrand J IM
270 Elizabeth Ave
Sinking Spring PA 19608
HIMMELSTEIN, MD, Fred R EM
825 Redwood Ave
Wyomissing PA 19610
HINRICHS, MD, Thomas F PM
Reading Hosp
Reading PA 19603
HIPPERT, DO, Robert K GP
805 N Richmond
Fleetwood PA 19522
HIRSH, MD, Paul D CD
200 N 13th Street
Reading PA 19604
HOFFER, MD, Richard S P
171 Yukon Court
Martinez GA 30907
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1330 Penn Ave
Wyomissing PA 19610
HOFFMAN, MD, Neil A PTH
Reading Hosp Pth Dept
Reading PA 19603
HOLM, MD, Eric K NS
Tri County Neurosurgery Assoc
Pottstown PA 19464
HORST, MD, Elmer L N
715 Lake Ave
Wyomissing PA 19610
HOSHAUER, MD, Cathy J PD
408 Greentree Village
Lebanon PA 17042
HOYT, MD, Ralph C GE
R D 1 Box 428-B
Birdsboro PA 19508
HUNTER, MD, John S GP
117 Philadelphia Ave
Shillington PA 19607
IMBER, MD, Irving IM
428 Walnut St
Reading PA 19601
IMPINK, MD, Robert R GS
P O Box 176
Shillington PA 19607
INNIS, MD, Patricia A FP
122 Oley Street
Reading PA 19601
JACKSON, MD, T Scott FP
R. D. #7, 438 Brimway Lane
Reading PA 19606
JACOBSON, MD, Martin A IM
4201 Kutztown Road
Temple PA 19560
JAXHEIMER, MD, Eric C CDS
1610 Lorraine Rd
Reading PA 19604
JAY JR, MD, Wendell T IM
600 Museum Rd
Reading PA 19610
JENCKES III, MD, George A IM
1325 Girard Avenue
Wyomissing PA 19610
JEWELL JR, MD, James H CDS
301 S Seventh Ave Ste 230
West Reading PA 19611
JIMERSON, MD, Cedric C GS
234 N Fifth St
Reading PA 19601
JOHNSON, MD, Alfred T FP
2240 Penn Ave
West Lawn PA 19609
JOHNSON, MD, Craig H NS
301 S. 7th Ave.
West Reading, PA 19611
JOHNSON, MD, Herbert C NS
601 Spruce St
West Reading PA 19611
JOHNSON, MD, William T AN
R D 1 Box 160
Reinholds PA 17569
JONES, MD, Marion K PM
R D 1 Box 250
Reading PA 19607
KAPLAN, MD, Lawrence M DR
Community Gen Hosp
Reading PA 19601
KAPLAN, MD, Robin L PUD
36 N 11st Street
Reading PA 19601

KARABELNIK, MD, Don GP
325 E Lancaster Ave
Shillington PA 19607
KASE, MD, James J IM
112 N 11th St
Reading PA 19601
KASTENBAUM, MD, Michael IM
409 S Tulpehocken Rd
Reading PA 19601
KAZI, MD, Sarwat A PD
1400 E Schuylkill Rd #C-8
Pottstown PA 19464
KEARNEY, MD, John M GS
120 Prospect St
Reading PA 19606
KEFFER, MD, William H OS
413 Oley St
Reading PA 19601
KEISER, MD, Edwin L GP
256 W Douglass St
Reading PA 19601
KELLER, MD, Eli J GP
1101 Gregg Ave
Reading PA 19607
KELLER, MD, John E OPH
1955 Lincoln Ave
Reading PA 19610
KELLER, MD, Lynwood V GP
106 S Fourth St
Reading PA 19602
KERSHNER, MD, Marilyn S R
The Reading Hosp & Med Ct
Reading PA 19603
KESSLER, MD, Paul R GP
711 Penn Ave
West Reading PA 19611
KIESS, MD, Robt Christian FP
200 N 13th St Ste 100
Reading PA 19604
KILLIAN III, MD, Calab L FP
2508 Hampden Blvd
Reading PA 19604
KIM, MD, Chung Shik IM
140 W Windsor St
Reading PA 19601
KING, MD, Weir L IM
120 Prospect St
Reading PA 19606
KLEAVELAND, MD, Joseph P IM
526 Jarden Road
Wyndmoor PA 19118
KLEIN, MD, Raymond A OBG
3611 Perk Ave
Reading PA 19606
KLEIN JR, MD, William J NEP
301 S Seventh Ave
West Reading PA 19611
KLEINER, MD, Anton J OBG
1435 Garfield Ave
Wyomissing PA 19610
KLEPPINGER, MD, Richard K GYN
301 S Seventh Ave
West Reading PA 19611
KLUFT, MD, Richard P P
301 S Seventh Ave
West Reading PA 19611
KNAPPMAN, MD, John W FP
819 Elm St
Riverview Park PA 19605
KNIAZER, MD, Barry OBG
250 N 12th Street
Reading PA 19604
KOCHU, MD, Steve END
Rt 422 & Old Airport Rd
Douglassville PA 19518
KOHL, MD, Stephen D OBG
601 Penn St #1000
Reading PA 19601
KOLTON, MD, Vladimir J GP
1448 Spruce Street
Reading PA 19602
KOREY, MD, Joseph J OBG
202 Opal Ave
Reading PA 19606
KOVALSKY, MD, Kenneth FP
9 Bristol Crt
Wyomissing Hills PA 19610
KRALJEVIC, MD, Juan E IM
200 N 13th Street
Reading PA 19604
KRAMER, MD, Randall K FP
226 E Wyomissing Ave
Mohnton PA 19540
KRIEBEL, MD, Dorothy E GP
R D 1 Box 9
Wernersville PA 19565
KRING, MD, Carroll S GP
7 Allison Rd Greenfields
Reading PA 19601
KUSSMAUL, MD, William G CD
4329 Larchwood Avenue
Philadelphia PA 19104
KUTSCHER, MD, Harlan A U
200 N 13th St
Reading PA 19604
LAMANNA, MD, John V PS
301 S Seventh Avenue
West Reading PA 19611
LAMBERT, MD, Kenneth P GP
233 W Main St
Kutztown PA 19530

LANE, MD, Charles D PTH
Reading Hosp & Medical Ctr
Reading PA 19603
LATMAN, MD, Stephen F ORS
2130 Penn Ave
West Lawn PA 19609
LATTIN, MD, Gary M CD
R D 3 488-K
Reading PA 19606
LEE, MD, Jung S FP
24 N 11th Street
Reading PA 19601
LEE, MD, Jung-Pil U
318 N Fifth St R D 3 Box 2
Reading PA 19601
LEINBACH JR, MD, Harvey D PD
1230 Parkside Dr
Reading PA 19611
LEISAWITZ, MD, Elliott G IM
1525 Rockland Street
Reading PA 19604
LEISAWITZ, MD, Paul A GP
1817 Linden St
Reading PA 19604
LENGEL, MD, Gary P GS
120 Prospect St
Reading PA 19606
LEONI, MD, Joseph U
931 Penn Ave
Wyomissing PA 19610
LEVAN, MD, John B IM
1415 Old Wyomissing Rd
Wyomissing PA 19610
LEVINE, MD, Alan P IM
1400 Ridge Avenue A-208
Reading PA 19607
LEVY, MD, Paul F IM
8 North 11th St
Reading PA 19601
LIGNELLI, MD, Gregory J NS
Tri County Neurosurgery Assoc
Pottstown PA 19464
LLOYD, MD, Edgar C OS
Reading Hosp An Dept
West Reading PA 19603
LODER, DO, Donald I FP
143 E Wall St
Leesport PA 19533
LOEPER, MD, Donald J FP
Route 100
Bally PA 19503
LOHMANN, MD, Albert E GS
1310 Farr Rd
Reading PA 19611
LONGENECKER, MD, FP
Benjamin E
4301 Kutztown Rd
Temple PA 19560
LONGENECKER, MD, Roger N FP
East Penn Med Ctr
Blandon PA 19510
LORD, MD, William H FP
918 Elizabeth Ave
Reading PA 19605
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223 E Lancaster Ave
Shillington PA 19610
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Manheim PA 17545
LUSCH, MD, Charles J HEM
301 S Seventh Avenue
West Reading PA 19611
LYNCH, MD, James D CD
515 Weidmen Avenue
Sinking Spring PA 19608
LYONS, MD, Clifford H FP
198 Oakmont Court
Reading PA 19607
LYONS, MD, Daniel C FP
P O Box 169 260 State St
Hamburg PA 19526
MAHMOOD, MD, Edna Z OPH
18 Tewkesburg Dr
Wyomissing PA 19610
MAIORANA, MD, S Leroy OBG
1153 Penn Ave
Wyomissing PA 19610
MALICK, MD, Gerald P OBG
301 S Seventh Ave
West Reading PA 19611
MANUBAY, MD, Marcelo A EM
1510 Eckert Ave
Reading PA 19602
MARCUS, MD, Jerome I CLP
Omega Health Care
Wyomissing PA 19610
MARIGLIO JR, MD, Joseph A IM
36 N 11th Street
Reading PA 19601
MARSHALL, MD, John E GP
R D 1 Box 70
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627 Walnut Street
Reading PA 19601
MARYNIAK, MD, Girard M OBG
301 S Seventh Avenue
West Reading PA 19611
MASSENGALE, MD, OBG
Alexander T
1286 Penn Avenue
Wyomissing PA 19610

MATTHEWS, MD, George R R
301 S Seventh Street
West Reading PA 19611
MAZUZ, MD, Meir CD
2112 Rosewood Court
Wyomissing PA 19610
MAZZA JR, MD, Patrick A FP
533 N 10th St
Reading PA 19604
MCCRAE, MD, Charles R ORS
R D 2 Box 96
Mohnton PA 19540
MCCRAE, MD, Marcia G PD
R D 2 Box 96
Mohnton PA 19540
MCKINNEY, MD, William L IM
317 N Sixth St
Reading PA 19601
MCLEAN, MD, James J IM
607 Trent Ave
Wyomissing PA 19610
MCTAMMANY, MD, J Robert OBG
102 Tasker Avenue
Shillington PA 19607
MEHARG JR, MD, John G IM
1307 Scott Court
Reading PA 19609
MELLON, MD, Robert CHP
701 E Neversink Rd
Reading PA 19606
MENDELSOHN, MD, Eugene OBG
911 N 26th Street
Reading PA 19606
MENGEL, MD, Roger G PUD
301 S Seventh Ave Ste 110
West Reading PA 19611
MENGES JR, MD, Job F ORS
1424 Penn Ave
Reading PA 19610
MERCURIO, MD, Teresa ON
301 S Seventh Avenue
West Reading PA 19611
MEYERS, MD, John L EM
320 E Fourth St
Shillington PA 19607
MILES, MD, Michael A EM
R D 1 Box 154
Birdsboro PA 19508
MILLER, MD, Henry N OS
Congressional Circle Apt 15F
Reading PA 19607
MILLER, MD, Jay B U
301 S Seventh Ave Ste 230
West Reading PA 19611
MINEHART, MD, Charles R CD
200 N 13th St Ste 201
Reading PA 19604
MITNICK, MD, Paul D NEP
301 S Seventh Ave Nep
West Reading PA 19611
MOFFITT, MD, Vincent J PD
1258 Penn Ave
Wyomissing PA 19610
MOLL, MD, Thomas B OPH
301 S Seventh Ave Ste 105
West Reading PA 19611
MONDALA-OCBO, MD, Elisa V AN
Two Chip Lane
Shillington PA 19607
MORGENSTERN, MD, Jeffrey H U
318 N Fifth St
Reading PA 19601
MORRIS, MD, Vernon R ORS
210 N Sixth St
Reading PA 19601
MORRISSEY JR, MD, E James ORS
1121 Penn Ave
Wyomissing PA 19610
MORROW, MD, Bert A GS
301 S Seventh Ave
West Reading PA 19611
MOSER, MD, John C FP
North & Walnut Streets
Morgantown PA 19543
MOSER, MD, Manny H PS
301 S Seventh Ave
West Reading PA 19611
MUHLENBERG, MD, John P PD
1981 Bern Rd
Wyomissing PA 19610
MULLIGAN, MD, Robert L NM
600 Brobst St
Shillington PA 19607
MURPHY, DO, Pamela D FP
623 N Fifth St
Reading PA 19601
MUVDI, MD, B Charles IM
120 Prospect Street
Reading PA 19606
NAGLE, MD, Arlington A GP
R D 1 Route 422
Womelsdorf PA 19567
NASE, MD, Paul K OPH
206 S Sixth Ave
West Reading PA 19611
NICHOLAS JR, MD, Peter D IM
307-1 Springside Dr East
Shillington PA 19607
NIEBAUM, MD, Albert H GP
9800 44Th Way N
Pinellas Park FL 33565

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549 Linden Street
Reading PA 19604
NUGENT, MD, Fred B GYN
#4 Eli Court
Reading PA 19607
OPLINGER, MD, Arthur F FP
2509 Perkiomen Ave
Reading PA 19606
ORQUIZA, MD, Clodualdo S U
931 Penn Ave
Wyomissing PA 19610
PACIULLI, MD, Raffaele ORS
200 N 13th St
Reading PA 19604
PADAYHAG, MD, Matias M US
Western Electric Co
Reading PA 19604
PADIYAR, MD, Ramdas B AN
14 Thornburg Road
Reading PA 19606
PAN, MD, Edward L ORS
200 N 13th St
Reading PA 19604
PAOLINI, MD, Mauro J PD
1981 Bern Road
Wyomissing PA 19610
PARIKH, MD, Shirish N IM
225 N 6th Street
Reading PA 19601
PARKER JR, MD, James H OPH
1500 Penn Avenue
Wyomissing PA 19610
PATADIA, MD, Chandrakant IM
Community General Hospital
Reading PA 19601
PATYK, MD, Richard A FP
209 S 17th Street
Reading PA 19602
PEARAH, MD, J David OPH
455 Penn Ave
Sinking Spring PA 19608
PELLEGRINI, MD, Vincent A OBG
301 S Seventh Ave
West Reading PA 19611
PENTA, MD, John M OTO
200 N 13th St
Reading PA 19604
PERILSTEIN, MD, Michael D RHU
200 N 13th St
Reading PA 19604
PERLMUTTER, MD, Gordon S R
301 S Seventh Avenue
West Reading PA 19611
PERRICCI, MD, Ellen S EM
325 Abington Dr
Wyomissing PA 19610
PEW, MD, Joseph N IM
3200 Reading Crest Ave
Reading PA 19605
PLYMYER, MD, Ray E IM
600 Museum Rd
Reading PA 19611
POMERANTZ, MD, Philip A NEP
200 N 13th Street
Reading PA 19604
POTKONSKI, MD, Leopold A P
245 Rosedale Dr
Pottstown PA 19464
PROBST, MD, Susan J OBG
120 Kent Way
West Reading PA 19611
PROSERPI, MD, Sergio V PS
301 S Seventh St
West Reading PA 19611
QUEREAU, MD, J Van Dyke OPH
1113 Reading Blvd
Reading PA 19610
RAMSEY JR, MD, Harry E HEM
301 S Seventh Avenue
West Reading 19611
REBER, MD, Howard F U
1310 East Wyomissing Blvd
Reading PA 19611
REED, MD, Clifford A N
301 S Seventh Avenue
West Reading PA 19611
REED, MD, Mark S CLP
Reading Hosp
Reading PA 19603
REES, MD, David B ORS
401 Buttonwood St
West Reading PA 19611
REICHARD, MD, Richard C GP
112 S Home Ave
Topton PA 19562
REIDENBERG, MD, Leon US
C-01 1801 Cambridge Ave
Wyomissing PA 19610
REIFSNYDER, MD, William H IM
2001 Bern Rd
Wyomissing PA 19610
REIGH, MD, Ernest E NS
601 Spruce Street
West Reading PA 19611
REINSEL, MD, Richard C GS
1314 Monroe Ave
Wyomissing PA 19610
RENKERT, MD, Elizabeth E FP
Po Box 363
Douglassville PA 19518

REUBEN, MD, Mark S PD
State Hl Rd & Wellington Blvd
Wyomissing PA 19610
RIGHTMYER, MD, John N GP
122 N Fourth St
Hamburg PA 19526
RIGHTS, MD, Theodore H GP
1164 N 13th St
Reading PA 19604
RISSER, MD, Mark G OS
25 N Kemp St
Kutztown PA 19530
ROBERTSON, MD, John J GP
30 E Main St
Kutztown PA 19530
ROBINSON, MD, Gary FP
Saint Joseph Hospital
Reading PA 19603
RODRIGUEZ, MD, Adolfo E GS
301 S Seventh Ave
West Reading PA 19611
ROKE, MD, Albert D FP
2304 Bell Dr
Reading PA 19609
ROMIG, MD, Ronald S CRS
109 Deborah Dr
Wyomissing Hills PA 19610
ROTENBERG, MD, Larry A P
845 N Park Rd
Wyomissing PA 19610
ROWAN, MD, Noel M IM
145 Merion Lane
Reading PA 19067
ROWAN, MD, Sandra K PD
310 N 11th St
Reading PA 19604
ROZANSKI, MD, Stanley J OM
941 Franklin St
Reading PA 19602
RUBRIGHT, MD, George L GP
R D 1 Box 358
Wernersville PA 19565
RUDOLPH, MD, Robert I D
1134 Penn Ave
Wyomissing PA 19610
RUNYEON, MD, William K GS
301 S Seventh Ave
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SAHOO, MD, Kashi Nath TR
St Josephs Hosp Dept Road
Reading PA 19603
SALERNO, MD, Francis A IM
500 E Philadelphia Ave
Shillington PA 19607
SALLER JR, MD, Devereux N OBG
415 Dorchester Avenue
Reading PA 19609
SARKER, MD, Muhammad A R FP
23 Tewesbury Dr
Wyomissing PA 19610
SCHAEBLER, MD, M Lee FP
701 Jefferson Blvd
Reading PA 19609
SCHARTEL, DO, Albert P GP
451 Douglass St
Reading PA 19601
SCHEFF, MD, Alice M NM
59 Winged Foot Dr
Reading PA 19607
SCHWARTZ, MD, Melvin H CD
Merion Gardens Apt A-302
Merion Station PA 19066
SCHWEIZER, MD, Robert R FP
137 E Penn Ave
Robesonia PA 19551
SCORNAVACCHI, MD, Joseph M U
R D 2 Clubhouse Rd 2
Bernville PA 19506
SCORNAVACCHI JR, MD, ORS
Joseph M
401 Buttonwood St
West Reading PA 19611
SCULLY, MD, John P D
Box 422 R D 2
Douglassville PA 19518
SEDA, MD, Hector J OTO
301 S Seventh Ave
West Reading PA 19611
SEIDEL, MD, Eric C FP
155 E Lincoln St
Robesonia PA 19551
SELLERS, MD, Robert W GP
805 N Richmond St
Fleetwood PA 19522
SEO, MD, Jin S AN
Berks Anesthesia Assoc Inc
Reading PA 19604
SEXTON JR, MD, George L OBG
301 S Seventh Ave
West Reading PA 19611
SHAFFER, MD, Eugene M GS
301 S Seventh Ave
West Reading PA 19611
SHAFFER, MD, Irvin G AN
145 N Sixth Street
Reading PA 19601
SHAH, MD, Harnish V PD
501 Warwick Dr
Reading PA 19610
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301 S Seventh Ave Ste 110
West Reading PA 19611

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Family Medical Center Rt 562
Reading PA 19606
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Reading PA 19604
SHEMANSKI, MD, Clem J GER
32 Fairway Rd
Reading PA 19607
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7 E Lancaster Ave
Shillington PA 19607
SHUGAR, MD, Gary L PTH
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Reading PA 19605
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SHUMAN, MD, Nancy A IM
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West Reading PA 19611
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601 S 19th Street Apt E-208
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SILVERMAN, MD, Edward J IM
1670 Penn Ave
Wyomissing PA 19610
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Wyomissing PA 19610
SMITH, MD, Barton L GE
301 S Seventh Ave
West Reading PA 19611
SMITH, MD, Raymond L PS
926 Penn Ave
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SOUDERS, MD, Thomas B OPH
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SPANGLER, DO, Martin L GP
900 N Fifth St
Reading PA 19601
SPANNUTH, MD, John R IM
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West Reading PA 19611
STELLA, MD, Victoria G FP
200 N 13th Street
Reading PA 19603
STELMACH, MD, Peter IM
1500 Oak La
Reading PA 19604
STELMACH, MD, W Peter FP
1500 Oak Lane
Reading PA 19604
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R D 2 Box 105
Bernville PA 19506
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West Reading PA 19611
STOLZ, MD, John C R
R D 3
Fleetwood PA 19522
STOLZ, MD, Jonathan L R
145 N Sixth St
Reading PA 19601
STOUDT, MD, Donald E N
301 S Seventh Ave
West Reading PA 19611
STOUDT, DO, Kathy J FP
711 N Fifth St
Reading PA 19601
STRAUSE JR, MD, Harold L OPH
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Reading PA 19601
STUARD, MD, I Donald PTH
The Reading Hosp & Med Ctr
Reading PA 19603
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SUWAN, MD, Manee PM
Reading Rehab Hosp
Reading PA 19607
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Reading Hospital
Reading PA 19601
TALLMAN, MD, Edwin H GP
R D 3 Box 126
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Sinking Spring PA 19608
TIETBOHL JR, MD, Ralph H FP
25 Stevens
West Lawn PA 19609
TOME, MD, Robert E FP
200 N 13th St
Reading PA 19604
TOMKIEWICZ, MD, Thaddeus J GP
1516 Eckert Avenue
Reading PA 19602

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Denver PA 17517
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Reading PA 19611
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Reading Hosp Med Ctr Xray
Reading PA 19603
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Reading PA 19601
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Reading PA 19606
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R D 7141
Reading PA 19606
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Reading PA 19602
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WERLEY, MD, Walter W R
604 N Fifth Street
Reading PA 19601
WESTCOTT, MD, Richard J GS
216 N Sixth Street
Reading PA 19601
WESTENDORP, MD, Andre C FP
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WIENER, MD, Stephen G D
1212 Liggett Ave
Reading PA 19611
WIEST, MD, Philip R OPH
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WILLIAMS, MD, Herman J GP
413 N Fifth St
Reading PA 19601
WILLIAMS, MD, John J GP
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Reading PA 19606
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Ephrata Comm Hosp
Ephrata PA 17522
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WITTELS, MD, Emanuel FP
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Reading PA 19601
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200 N 13th St
Reading PA 19604
WONG, MD, James IM
200 N 13th St
Reading PA 19604

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WORNAS, MD, Christian G IM
227 N Sixth St
Reading PA 19601
WOTRING, MD, John M OPH
632 Waverly St
Shillington PA 19607
WOYNAROWSKI, MD, John A FP
826 N Fifth St
Reading PA 19601
WUMMER, MD, Brian A FP
R D 1
Womelsdorf PA 19567
YEAGLEY, MD, Heber E DR
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YOH, MD, Harold N GP
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YOUNDT, MD, Luke B R
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Adamstown PA 19501
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Reading PA 19601
YOUNGBERG, MD, Russell E PM
Univ De Montemonelos #16
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West Reading PA 19611
ZERBY, MD, Jeffrey C OBG
601 Penn St
Reading PA 19601
ZIENTEK, MD, Leon T GP
Family Med Ctr
Reading PA 19606
ZISCHKAU, MD, Douglas D FP
Medical Office Ctr
Reading PA 19604
ZOBIAN, MD, Edward J OPH
206 S Sixth Ave
West Reading PA 19611
ZOLGHADRI, MD, Siavash IM
606 Court St Ste 308
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311 Union Street
Hollidaysburg PA 16648
BEERS, MD, Kenneth L GI
501 Howard Ave
Altoona PA 16601
BELIS, MD, Theodore E I
501 Howard Ave
Altoona PA 16601
BENITEZ, MD, Francisco W EN
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BIESINGER, MD, George J OB
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Altoona PA 16601
BISACCO, MD, Stephen J OB
2602 Eighth Ave
Altoona PA 16602
BISHOP, MD, David W OP
R D 4 Box 165-A
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BOWERS, MD, Leroy W F
P O Box 203
Tyrone PA 16686
BOWMAN, MD, David H OP
14 Wicklow Ct
Hollidaysburg PA 16648
BRADLEY, MD, Vernon F OB
501 Howard Ave
Altoona PA 16601
BRIDENBAUGH, MD, Robert P II
Cove Med Ctr Nason Dr
Roaring Spring PA 16673
BROCK, MD, David C F
501 Howard Ave
Altoona PA 16601
BULGER, MD, Richard H G
New Enterprise PA 16664
BURKET, MD, Daniel G G
1122 28Th Avenue
Altoona PA 16601
BURKET, MD, Louis C P
322 Fifth Ave
Altoona PA 16602

BURKET, MD, Ramon C FP
Cove Med Ctr Nason Dr
Roaring Spring PA 16673
CASSIDY, MD, Joseph A GP
309 Powell Ave
Cresson PA 16630
CATTON, MD, Domenic J AN
P O Box 275
Martinsburg PA 16662
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117 Tenthe Ave Juniata
Altoona PA 16601
CHEUNG, MD, Hoo J GP
1113 Penn St
Hollidaysburg PA 16648
CHO, MD, Doo W P
615 Howard Ave
Altoona PA 16601
CHOPRA, MD, Ramesh K PD
1205 14Th Ave
Altoona PA 16601
CONNOLE, MD, John F OPH
141 Larch St
Hollidaysburg PA 16648
COTTLE, MD, Betty L AN
25 Sylvan Dr
Hollidaysburg PA 16648
COTTLE, MD, Harold R PTH
25 Sylvan Drive
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CRAWFORD JR, MD, Ralph W GYN
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DCRUZ, MD, Joseph F PD
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DEFRANCISCO, MD, Lance C GE
Executive 1-Annex
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DEKONING, MD, Johannes L FP
5144 W Chestnut Avenue
Altoona PA 16601
DELERME, MD, Augusto N HNS
600 Chestnut Ave
Altoona PA 16601
DESANTES, MD, Frank A OTO
1219 14Th Ave
Altoona PA 16601
DIBERT, MD, Lawrence W OM
306 Plum St
Williamsburg PA 16693
DIETRICK, MD, Ronald A OBG
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Altoona PA 16601
DLUZANSKY, MD, James J U
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RVIN, MD, Lawrence M GP
931 Main St
Coalport PA 16627
ABINYI, MD, Geza T OPH
1331 12Th Ave
Altoona PA 16603
ALL, MD, Michael H U
1209 14Th Ave
Altoona PA 16601
EES JR, MD, Arch W GP
501 Howard Ave
Altoona PA 16601
ERNANDO, MD, Michael F PM
1109 Robin Ln
Duncansville PA 16635
LEMING, MD, George E AN
Oak Knoll
Hollidaysburg PA 16648
OCHLER, MD, Francis J GS
501 Howard Ave
Altoona PA 16601
ORSE JR, MD, David P GS
Running Deer Farm
Saxton PA 16678
RIDAY, MD, Daniel M OBG
Clay Ave Ext
Tyrone PA 16686
ULCHIERO, MD, Gregory J ORS
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EITGEY, MD, William I IM
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BBONS, MD, William P PS
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LOT, MD, Jean M AN
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GRAB, MD, Edmundo M OBG
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Ms Marjorie E
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HEATON, MD, Vincent W GP
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KANSAL, MD, Raj G U
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702 18Th St
Altoona PA 16602
MANIGLIA, MD, Anthony J IM
702 18Th Street
Altoona PA 16602
MATTAS, MD, Oliver E U
1213 14Th Ave
Altoona PA 16601
MCKINNEY, MD, Henry D D
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Altoona PA 16601
MEISNER, MD, Marvin H CD
1414 Eighth Ave
Altoona PA 16602
MELOY, MD, John H ND
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81 Crabtree Dr
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HEDRICK, MD, Gerald W FP
1733 Diamond St
Sellersville PA 18960
HELZNER, MD, Eileen C GP
3668 Oak Lane
Furlong PA 18925
HELZNER, MD, Richard C R
8118 Old York Road
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HERMANN, MD, Christopher P IM
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SACKHEIM, MD, Robert AN
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MCKEE, MD, Robert E GS
939 E Brady St
Butler PA 16001
MEHTA, MD, Varsha J PUD
V A Hosp Newcastle St
Butler PA 16001
MIRANDA, MD, Cesar P IM
510 N Main St
Butler PA 16001
MOLCHANY, MD, Ernest P FP
Chicora Med Ctr
Chicora PA 16025
MOORE, MD, Ernest E GP
165 Brugh Ave 305
Butler PA 16001
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Butler PA 16003
NALLATHAMBI, MD, IM
Swamikkan A
131 E Cunningham St
Butler PA 16001
NAST, MD, Max S GP
510 E Locust St
Butler PA 16001
NEY, MD, F Gregg R
1005 W Ketler Dr
Grove City PA 16127
NIETO, MD, Victor E EM
119 Hampton Crt
Butler PA 16001
NUNNA, MD, Nagabhushanam IM
230 S Washington St
Butler PA 16001
NUNNA, MD, Sitalakshmi C GP
230 S Washington St
Butler PA 16001
PARK, MD, Boyd N AN
126 Green Hill Dr
Butler PA 16001
PATEL, MD, Mayur ON
230 S Washington St
Butler PA 16001
PAUL, MD, Jay PUD
1258 Lakevue Dr
Butler PA 16001
PIRRELLO, MD, Anthony M CLP
Butler County Mem Hosp
Butler PA 16001
PRASAD, MD, Mahadevappa M IM
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Butler PA 16001
REEFER, MD, John C IM
134 Randy Dr
Butler PA 16001
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118 Edgewood Rd
Butler PA 16001
SEKARAN, MD, Kamalesh K PD
117 S Mckean St
Butler PA 16001
SEKARAN, MD, Somasundaram K U
117 S Mckean St
Butler PA 16001
SETHI, MD, Surendra K CD
230 S Washington St
Butler PA 16001
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Butler PA 16001
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21 Med Arts Bldg
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100 Thompson Ave Ste A
Butler PA 16001
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316 N Main St 2nd Fl
Butler PA 16001
TREDENNICK, MD, Charles N OPH
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TURNBLACER, MD, Charles B OTO
340 N Main St
Butler PA 16001
WAHL, MD, Dayne F GP
835 Edmond St
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WEISSMAN, MD, Jerry OPH
156 N Main Street
Butler PA 16001
WELLMAN, MD, Richard H OS
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Windber PA 15963
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Johnstown PA 15905
ASSAR, MD, Suda P PD
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Johnstown PA 15905
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Johnstown PA 15905
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Johnstown PA 15905
BANTLY, MD, Victor S GP
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Johnstown PA 15902
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Johnstown PA 15901
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Johnstown PA 15905
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Johnstown PA 15901
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Johnstown PA 15905
MARAVALLI, MD, Camille J OPH
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Johnstown PA 15901
MARI-MAYANS, MD, Juan B EM
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Johnstown PA 15905
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Johnstown PA 15905
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% Hamad Gen Hosp
Qatar
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MITAL, MD, Nirmal G DR
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MITCHELL, MD, Donald D OBG
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Johnstown PA 15905
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755 Luzerne St
Johnstown PA 15905
MORGAN, MD, Owen K OPH
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Johnstown PA 15901
PANEK, MD, Bernard S FP
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Johnstown PA 15901
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Windber PA 15963
PARONISH, MD, William J FP
Albina Way
Latrobe PA 15650
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Johnstown PA 15905
PATTERSON, MD, Joseph R R
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Johnstown PA 15905
PAVICH, MD, Rudolph W OM
1128 Dithridge Dr
Johnstown PA 15905
PICKERILL, MD, Robert G PUD
524 Grove Ave
Johnstown PA 15902
PIDUTTI, MD, Richard W FP
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Johnstown PA 15901
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47 Osborne St
Johnstown PA 15905
POTE JR, MD, Harry H IM
353 Market St
Johnstown PA 15901
PRICE, MD, Richard E OM
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Johnstown PA 15915
PRUCHNIC, MD, William F IM
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Johnstown PA 15905
QUINN, MD, John R AN
320 Main St
Johnstown PA 15901
RAYMOND, MD, Joseph W OPH
U S Natl Bank Bldg Rm 907
Johnstown PA 15901
RAYMOND, MD, Paul A FP
235 Collegiate Dr
Johnstown PA 15904
REESE, MD, Jack W GS
213 10Th St
Barnesboro PA 15714
REYES, MD, Alfredo M EM
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Barnesboro PA 15714
RHOADS, MD, Harry M GP
436 Park Ave
Johnstown PA 15902
RICHEY, MD, James E GE
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Johnstown PA 15905
RIDELLA, MD, Peter J ORS
2222 Woodcrest Dr
Johnstown PA 15905
RITTER, MD, Mario IM
307 Vine St
Johnstown PA 15901
ROCK, MD, James A PTH
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Johnstown PA 15901
ROGERS, MD, George E FP
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1086 Franklin St Xray
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SAHLANEY, MD, William J FP
Seward PA 159[illegible]4

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Johnstown PA 15905
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Johnstown PA 15905
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Johnstown PA 15905
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Johnstown PA 15901
SEWAK, MD, Michael E GP
268 Main St
Conemaugh PA 15909
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Johnstown PA 15904
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Johnstown PA 15901
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SIEPER, DO, William J TR
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SLOAN, MD, Gerald H U
R D 1
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SMITH, MD, William P GP
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SMOYER, MD, Ronald L FP
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SOBIESKI, MD, Joseph IM
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SOISSON JR, MD, Ferdinand L OBG
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SRIVASTAVA, MD, Sheonath P IM
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Johnstown PA 15904
STADTMILLER, MD, Richard J FP
Deyarmin Bldg
St Michael PA 15951
STEIN, MD, Alan H EM
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Johnstown PA 15905
STOTLER, MD, Charles W FP
317 Bloomfield Street
Johnstown PA 15904
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Johnstown PA 15901
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HENDRICKS, MD, Robert T GS
507 Jackson Park Dr
Meadville PA 16335
HIBBARD, MD, Alanson O GP
838 Park Ave
Meadville PA 16335
HOLLAND JR, MD, William T OPH
899 Grove St
Meadville PA 16335
KELLOGG, MD, Ronald A FP
764 Kennedy St
Meadville PA 16335
KIRKPATRICK, MD, Robert L GS
1058 S Main St
Meadville PA 16335
KIRKPATRICK JR, MD, David D IM
279 Walnut St
Meadville PA 16335
LARSON, MD, James H PTH
Meadville City Hospital
Meadville PA 16335
LAUB, MD, Curtis H ORS
461 Pine St
Meadville PA 16335
LAVAY, MD, Donald E DR
Spencer Hosp 1059 Grove St
Meadville PA 16335
MARTIN, MD, James W GP
Water St
Conneaut Lake PA 16316
MCLAMB, MD, James R ORS
766 Liberty St
Meadville PA 16335
MOAKEH, MD, Mohamed U
773 N Main St
Meadville PA 16335
MORRIS, MD, Rebecca F PD
764 Kennedy St
Meadville PA 16335
MORRIS, MD, William J OBG
R D 5 Nancy Dr
Meadville PA 16335
MOYERS, MD, Robert N GP
764 Kennedy St
Meadville PA 16335
NESBITT, MD, John B IM
279 Walnut St
Meadville PA 16335
ORDINARIO JR, MD, Vicente R R
Third St
Conneaut Lake PA 16316
OWENS, DO, Edward J FP
118 Railroad St
Cambridge Springs PA 16403
PAGNIELLO, MD, Lucia A
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Meadville PA 16335
PIROCH, MD, Joseph G CD
R D 4 Brooks Rd
Meadville PA 16335
POUX, MD, Paul T GP
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225 W Grandview
Erie PA 16508
SAAVEDRA, MD, Diogenes A GS
664 Highland Ave
Meadville PA 16335
SANTORA, MD, Robert A OPH
505 Poplar St
Meadville PA 16335
SARAIN, MD, Antonio N GP
Franklin St
Linesville PA 16424
SMART, MD, Lawson C ORS
766 Liberty St
Meadville PA 16335
TAYLOR JR, MD, John O GS
843 Park Ave
Meadville PA 16335
THOMAS, MD, Christopher W IM
176 N Main St
Meadville PA 16335
TRANSUE, MD, Seward M P
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719 Susquehanna Rd
Meadville PA 16335
WATSON, MD, Thomas M CDS
505 Poplar St
Meadville PA 16335
ZEHNER, MD, Luther R GP
918 Diamond Park
Meadville PA 16335
ZELEN, MD, Randy S NEP
139 Linda Lane
Meadville PA 16335
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505 Poplar St
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BEACHY, MD, Stanley C OBG
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Carlisle PA 17013
BLACKSMITH JR, MD, Gary L FP
220 Wilson St Ste #204
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BRANSCUM, MD, George P GP
850 Walnut Bottom Rd
Carlisle PA 17013
BRAZEL, MD, Joseph F IM
220 Wilson St
Carlisle PA 17013
BRIER, MD, Peter M IM
1106 Carlisle Rd
Camp Hill PA 17011
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850 Walnut Bottom Rd
Carlisle PA 17013
BRYAN, MD, Frank S ORS
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Carlisle PA 17013
BRYANT, MD, David W GS
850 Walnut Bottom Rd
Carlisle PA 17013
CAREY, MD, Philip D IM
850 Walnut Bottom Rd
Carlisle PA 17013
CASTRINA JR, MD, Frank P IM
220 Wilson St
Carlisle PA 17013
CHERRY, MD, Steven B OBG
816 Belvedere St
Carlisle PA 17013
COOKE, MD, Nora PD
60 N East St
Carlise PA 17013
COX, MD, Paul A OPH
313 S Hanover St
Carlisle PA 17013
CRIST, MD, Henry S PTH
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Carlisle PA 17013
DAGEN, MD, J Edward U
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Carlisle PA 17013
DAVIS, MD, H Robert FP
P O Box 38
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17 S West St
Carlisle PA 17013
EHLY, MD, George W EM
R D 1
East Berlin PA 17316
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Carlisle PA 17013
FRITCHLEY, MD, Rodney B GS
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1106 Carlisle Rd
Camp Hill PA 17011
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274 Wilson St
Carlisle PA 17013
GREEN, MD, Thomas J ORS
220 Wilson St Ste 104
Carlisle PA 17013
GREEN 3RD, MD, Joseph E IM
850 Walnut Bottom Rd
Carlisle PA 17013
GUISTWITE, MD, Kenneth R FP
1225 Sadler Dr
Carlisle PA 17013
HALL II, MD, Robert F R
161 Candlelite Dr
Carlisle PA 17013
HARTZELL, MD, David L OPH
850 Walnut Bottom Rd
Carlisle PA 17013
HAYS, MD, E Blaine OBG
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Carlisle PA 17013
HELY, MD, Daniel P ORS
850 Walnut Bottom Rd
Carlisle PA 17013
HERSPERGER, MD, Webb S OTO
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Carlisle PA 17013
HERTZLER JR, MD, John V IM
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Carlisle PA 17013
HOERNER, MD, Oscar G GP
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HOLLEN, MD, Robert A FP
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Carlisle PA 17013
HOUGH, MD, Rodney K FP
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Carlisle PA 17013
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Carlisle PA 17013
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Carlisle PA 17013
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Carlisle PA 17013
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Carlisle PA 17013
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Carlisle PA 17013
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Carlisle PA 17013
ONG, MD, George P D
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BARSANTI, MD, Ronald G GS
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Elizabethtown PA 17022
BATES, MD, Mark A IM
R D 2 Box 300-A
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75 Cedar Ave
Hershey PA 17033
BEALE, MD, Benjamin R GP
225 Hummel Ave
Lemoyne PA 17043
BEANE, MD, Howard C U
789 Poplar Church Rd
Camp Hill PA 17011
BECK, MD, Gunhilde M EM
R D 1 Dauphin River Rd
Dauphin PA 17018
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Harrisburg PA 17110
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Mount Joy PA 17552
BELLINGER, MD, Mark F U
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Camp Hill PA 17011
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809 Conodguinet Dr
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221 S Third St
Lemoyne PA 17043
BLACKSMITH, DO, William A OS
304A St Johns Road
Camp Hill PA 17011
BOAL, MD, Danielle K PDR
804 Riverview Rd
Lemoyne PA 17043
BOAL, MD, Richard J ORS
875 Poplar Church Road
Camp Hill PA 17011
BONAFEDE, MD, Peter L GP
3525 Walnut St
Harrisburg PA 17109
BOWER, MD, Harry B GP
2561 N Sixth St
Harrisburg PA 17110
BOWER, MD, James H FP
614 Main St
Lykens PA 17048

BOWMAN, MD, Herbert S HEM
504 Ohio Ave
Lemoyne PA 17043
BOWMAN JR, MD, Thomas E GS
2820 Arcona Rd
Mechanicsburg PA 17055
BOYD, MD, William J IM
131 State St
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13 Polaris Briarcrest
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Harrisburg PA 17110
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BRENNER, MD, Louis O IM
2223 N Second St
Harrisburg PA 17110
BRICKNELL, MD, Paul P AN
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Hershey PA 17033
BRITTON, MD, L Lynne IM
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BROOK, MD, Gail S PD
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Hershey PA 17033
BROOKS, MD, Harry R GP
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BUCHANAN, MD, James R GS
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Harrisburg PA 17109
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551 Sidewood
Erie PA 16505
GARVEY, MD, William P GP
3860 Stellar Dr
Erie PA 16506
GAUGHAN, MD, Joseph F FP
539 Montmarc Blvd
Erie PA 16504
GEIGLE, MD, Carl F CRS
3216 State St
Erie PA 16508
GEORGE, MD, Jacob TS
225 W 25th Street
Erie PA 16502
GERMAN, MD, Antonio I PTH
232 W 25th St
Erie PA 16544
GMUER, MD, Paul J GE
5761 Georgetown Dr
Erie PA 16509
GOKHALE, MD, Sudhir B OTO
1611 Peach St
Erie PA 16501
GOLD, MD, Jack PD
926 W 38th St
Erie PA 16508
GOODRICH, MD, Jack K NM
104 E Second St
Erie PA 16507
GRAHAM JR, MD, Galen E IM
148 W 21st Street 2nd Fl
Erie PA 16502
GRAJEWSKI, MD, Robert S U
104 E Second St Sixth Floor
Erie PA 16507
GUELCHER, MD, Robert T OTO
225 W 25th Street
Erie PA 16502
GUSTIN, MD, Thomas A P
5606 Bonaventure Dr
Erie PA 16505
GUTHLEBEN, MD, John G OBG
2104 State St
Erie PA 16503
HAIBACH, MD, Raymond A FP
1589 W 54th St
Erie PA 16509
HANSON, MD, Elbert L CDS
2314 Sassafras St
Erie PA 16502
HARDY, MD, Heidrun D AN
406 Rondeau
Erie PA 16505
HEIBEL, MD, Richard H CD
224 W 26th Street
Erie PA 16508
HENDERSON, MD, Ellsworth W GP
30 W High St
Union City PA 16438
HENDRICKS JR, MD, William C NS
202 E Second St
Erie PA 16507
HILEMAN, MD, James D GP
315 York St
Corry PA 16407
HINES, MD, Joseph H END
300 State Street
Erie PA 16507
HIRSCH, MD, Jack H GP
2963 Peach St
Erie PA 16508
HO, MD, Raymond C GP
R D 4 112 Hillcrest Dr
Corry PA 16407
HO, MD, Szekey P
Philadelphia State Hosp
Philadelphia PA 19114
HOLMES, MD, Thomas R FP
5165 Imperial Pwy
Girard PA 16417
HOU, MD, Ching W OBG
740 Wanye St
Corry PA 16407
HRINDA, MD, John G FP
920 Pine Tree Drive
Girard PA 16417
HUDSON, MD, Howard L R
104 E Second St
Erie PA 16507
HUSAIN, MD, Akhter F P
520 Elizabeth Lane
Erie PA 16505
HYATT, MD, Floyd R R
St Vincent Hlth Ctr
Erie PA 16544
JAECKLEIN, MD, Frederick P HEM
104 E Second St
Erie PA 16507
JAGEMAN, MD, James R US
2104 Zimmerly Rd
Erie PA 16509
JAGEMAN, MD, John C IM
2104 Zimmerly Rd
Erie PA 16509
JANA, MD, Dilip K IM
4607 Highview Blvd
Erie PA 16509
JENKINS, MD, Jay L HEM
104 E Second St
Erie PA 16507
JOY, MD, Charles A IM
Four W 34Th St
Erie PA 16508
JUANG, MD, Richard C GS
318 E Main St
Girard PA 16417
JURGENS, MD, Kenneth H PTH
St Vincent Hlth Ctr
Erie PA 16544
KALAGAYAN, MD, Hector J GS
R D 3 Meadville Rd
Union City PA 16438
KALKHOF, MD, Thomas C GER
P O Box 7265
Erie PA 16510
KAMINSKY, MD, Anthony F U
2314 Sassafras St
Erie PA 16502
KAMINSKY, MD, James F AN
3520 Beech Ave
Erie PA 16508
KARAMANIAN, MD, Agop V AN
201 State St
Erie PA 16550
KARLE, MD, John G OPH
103 Wilderness Dr
Naples FL 33942
KARSH, MD, Carl A GP
160 Oakmont Ave
North East PA 16428
KEISTER, MD, Stephen R IM
300 State Street
Erie PA 16507
KHERA, MD, Dinesh C IM
238 W 22nd St
Erie PA 16502
KING, MD, Roy J FP
225 E Sixth St
Erie PA 16507
KISH, MD, George F CDS
104 E Second St
Erie PA 16507
KLAWON, MD, David L PTH
St Vincent Hlth Ctr
Erie PA 16544
KOPYCINSKI, MD, Clark F FP
4620 Buffalo Rd
Erie PA 16510
KROEMER, MD, Peter O FP
201 Waterford Street
Edinboro PA 16412
KUHN, MD, Richard H FP
P O Box 740
Erie PA 16544
KUKLINSKI, MD, Lawrence M ORS
204 W 26th St
Erie PA 16508
LAMBERTON, MD, William D FP
213 E 41st St
Erie PA 16504
LAMBERTON, MD, William F IM
213 E 41st St
Erie PA 16504
LAMP, MD, Albert L OS
232 W 25th St
Erie PA 16544
LANGE, MD, John A P
1611 Peach St #455
Erie PA 16501
LARA, MD, Henry R PTH
Hamot Med Ctr
Erie PA 16512
LASHER, MD, J Donald GS
316 W 23rd Street
Erie PA 16502
LASHER, MD, Robert L GS
316 W 23rd Street
Erie PA 16502
LAVIN, MD, David M IM
104 E Second St
Erie PA 16507
LAYDEN, MD, Paul W ORS
6730 W Manchester Beach Rd
Fairview PA 16415
LEE, MD, Dong P GP
3560 Culpepper Dr
Erie PA 16506
LEE, MD, In W P
3102 El Corto Way
Erie PA 16506
LEONE, MD, Charles R FP
238 W 22nd St
Erie PA 16502
LEVY, MD, David J GE
140 W Second St
Erie PA 16507
LIPMAN, MD, Sidney P OTO
920 W Arlington Rd
Erie PA 16509
LLOYD, MD, Gerald R FP
315 York St
Corry PA 16407
LOEB, MD, Robert L IM
557 W Eighth St
Erie PA 16502
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Erie PA 16507
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Erie PA 16502
LYONS, MD, Richard C U
104 E Second St
Erie PA 16507
MACLACHLAN, MD, William W OTO
1611 Peach St
Erie PA 16501
MAINZER, MD, Francis K NS
Five E 34Th St
Erie PA 16504
MAJERONI, MD, Barbara A FP
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Erie PA 16550
MAKAROWSKI, MD, William S RHU
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Erie PA 16502
MALJOVEC, MD, Joseph J OBG
4817 Hilltop Rd
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225 W 25th St
Erie PA 16502
MANASSE, MD, Howard S OPH
2314 Sassafras Street
Erie PA 16502
MANGO, MD, Albert E GP
128 E Seventh St
Erie PA 16501
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1945 S Shore Dr
Erie PA 15605
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226 Monaca Drive
Erie PA 16505
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Erie PA 16502
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1455 W 38th St
Erie PA 16508
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60 N Lake St
North East PA 16428
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104 E Second St
Erie PA 16507
MCCLELLAN, MD, Joseph R IM
224 W 26th Street
Erie PA 16508
MCCOMBS, MD, Ray D GP
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Erie PA 16505
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104 E Second St
Erie PA 16550

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MERSKI, MD, Anthony T AN
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MILLER, MD, Roland E FP
Hamot Med Ctr Ambulatory Care
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Erie PA 16507
MIRSKY, MD, Howard A U
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Erie PA 16507
MISCHLER, MD, Forrest C GS
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Erie PA 16507
MITRA, MD, Atin K US
232 W 25th St
Erie PA 16544
MORK, MD, Gustave W PD
1611 Peach Prof Bldg
Erie PA 16501
MORRIS, MD, John L FP
High St
Edinboro PA 16412
MOYER, MD, Thelbert R PM
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Erie PA 16506
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Erie PA 16508
MRAZ, MD, John P D
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Erie PA 16508
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502 E 12th St
Erie PA 16503
NADWORNY, MD, Howard A ID
2314 Sassafras Street Ste 201
Erie PA 16502
NAGLE, MD, Douglas B R
104 E Second St 5th Fl
Erie PA 16507
NAGLE, MD, Richard W DR
104 East Second St
Erie PA 16507
NAIR, MD, Krishnan K OTO
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Erie PA 16501
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1123 W 38th St
Erie PA 16508
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Erie PA 16512
NOLAN JR, MD, Thomas F GS
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Erie PA 16502
OVERFIELD, MD, Edward M PUD
2618 Sigsbee St
Erie PA 16508
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5207 Maplewood Ct
Erie PA 16506
PARSONS, MD, William H P
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Erie PA 16505
PATEL, MD, Kantilal C AN
1217 St Mary Dr
Erie PA 16509
PATEL, MD, Vinod M GE
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Erie PA 16502
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Erie PA 16507

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Erie PA 16505
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3215 Erie St
Erie PA 16508
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Erie PA 16506
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ROCHE, MD, Robert J OBG
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Erie PA 16503
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Erie PA 16505
ROMANO-JANA, MD, RHU
Lourdes R
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Erie PA 16509
ROOS, MD, Alfred T FP
3125 French St
Erie PA 16504
ROQUIZ, MD, Eliseo M AN
232 W 25th St
Erie PA 16544
ROSEN, MD, William U
7694 Royann Drive
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Erie PA 16507
ROTH, MD, Russell B U
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Erie PA 16502
ROZWADOWSKI, MD, Jack V CLP
406 Wilkins Rd
Erie PA 16505
RUSIN, MD, Lawrence C CRS
1153 Hilltop
Erie PA 16509
RUSSO JR, DO, Anthony P AN
5130 Uhlman Rd
Fairview PA 16415
SALMON, MD, James H NS
225 W 25th St
Erie PA 16512
SALVATORE, MD, Michael R FP
611 Virginia Ave
Erie PA 16505
SAMARASINGHE, MD, Gunasiri AN
3220 Kingston Ct
Erie PA 16506
SANDSTROM, MD, Paul H R
104 E Second St
Erie PA 16507
SANTOMENNA, MD, Michael A GS
238 W 22nd St
Erie PA 16502
SANTOSO, MD, Limjadi IM
2618 Parade
Erie PA 16504
SARDESAI, MD, Prabhaker G TS
104 E Second St
Erie PA 16507
SCHAAF, MD, John T PUD
2618 Sigsbee St
Erie PA 16508
SCHELL, MD, Stephen E OTO
1611 Peach Street
Erie PA 16501
SCHLABACH, MD, Donald M DR
104 E Second St 5th Fl
Erie PA 16507
SCHUSTER, MD, James L ORS
140 W Second St Ste 100
Erie PA 16507
SCIBETTA, MD, Mario P TR
104 E Second St 5th Fl
Erie PA 16507
SCULLY, MD, Dennis M FP
1444 W 38th St
Erie PA 16508
SEGU, MD, Subramanyam OPH
350 W Tenth St
Erie PA 16502
SEIFERTH, MD, William J IM
309 Connecticut Dr
Erie PA 16505

SEMPLE, MD, Joseph M AN
3204 State St
Erie PA 16508
SHARMA, MD, Sukh D CD
6351 Lakeshore Dr
Erie PA 16605
SHEPPARD, MD, Frank J GS
Corry Memorial Hospital
Corry PA 16407
SHERAFAT, MD, Mostafa TS
104 E Second St
Erie PA 16507
SHIN, MD, Maung T AN
5606 Swanville Rd
Erie PA 16506
SHIPLEY, MD, Alan E EM
745 E 40th St #8
Erie PA 16504
SHIVDE, MD, Pinakini NPM
104 E Second St
Erie PA 16507
SHUBERT, MD, Edward AN
1324 S Shore Dr Apt 405
Erie PA 16505
SIMORA, MD, Felix S P
1611 Peach St
Erie PA 16501
SKOVRON, MD, Michael ORS
716 Sassafras St
Erie PA 16501
SMITH, DO, James A M IM
2010 W 38th Street
Erie PA 16508
SMYTH, MD, William T PTH
St Vincent Hlth Ctr Pth Dept
Erie PA 16544
SNIDER, MD, B Leonard D
3416 State St
Erie PA 16508
SNOW, MD, Daniel S EM
525 W Tenth St
Erie PA 16502
SNOW, MD, Ross A FP
525 W Tenth St
Erie PA 16502
STAMM, MD, Barry D OPH
104 E Second St
Erie PA 16507
STEINBRINK, MD, William H OBG
140 W Second St
Erie PA 16508
STENCLIK, MD, Mark J ORS
508 Lincoln Ave
Erie PA 16505
STRATTON, MD, Robert D OPH
1611 Peach St Suite 105
Erie PA 16501
STUART, MD, Robert B FP
1565 W 38th St
Erie PA 16508
SUMMERS, MD, David S N
2314 Sassafras St Ste 206
Erie PA 16502
SUPPA, MD, Osvaldo S DIA
300 State Street
Erie PA 16507
SURI, MD, Ashok K U
202 E Second Street
Erie PA 16507
SUSANN, MD, Philip W GS
Hamot Med Bldg
Erie PA 16507
SUSI, MD, Jesse G ORS
1465 Persimmon Ln
Fairview PA 16415
TABORA, MD, Emmanuel J GS
P O Box 6308
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TAN, MD, Wilfredo S CDS
104 E Second St
Erie PA 16507
TATE, MD, J Harrison GP
1174 Hilltop Rd
Erie PA 16509
TAVANA, MD, Manoucher GS
238 W 22nd St
Erie PA 16502
TAVARES, MD, Joao O ORS
1611 Peach St Ste 350
Erie PA 16501
TEED, MD, Edward L OPH
3330 Peach Street
Erie PA 16508
THEUERKAUF JR, MD, CRS
Frank J
3216 State St
Erie PA 16508
THOMAS JR, MD, James J OBG
210 E Second St
Erie PA 16507
TOOZE, MD, Frank M PS
P O Box 3496
Erie PA 16508
TOPERZER, MD, Betty C FP
104 E Second St
Erie PA 16507
TSAI, MD, Ming Che CD
102 Forest La
Corry PA 16407
TURNER, MD, Thomas H FP
7176 Main Street Box Ee
Fairview PA 16415

UNDERHILL, MD, William L CD
104 E Second St 7th Fl
Erie PA 16507
VANDAMIA, MD, Donald N GP
1589 W 54th St
Erie PA 16509
VANVORIS, MD, Lee P ID
104 E Second St
Erie PA 16507
VARCELOTTI, MD, Jorge R GS
2803 Madeira Dr
Erie PA 16506
VATAVUK, MD, Mark K FP
1158 Appletree Ln
Erie PA 16509
VEMULAPALLI, MD, Kutumbarao AN
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Erie PA 16507
VEMULAPALLI, MD, OBG
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Erie PA 16506
VENABLE JR, MD, John E EM
5693 Bushnell Rd
Conneaut OH 44030
VERDECCHIA, MD, Leo M OBG
1611 Peach St
Erie PA 16501
VILLANOS, MD, Jesus M PD
33 W High St
Union City PA 16438
WALKER, MD, James F IM
302 W Ninth St
Erie PA 16502
WALLACE, MD, Wilbur S PH
790 Lincoln Ave
Erie PA 16505
WALLERSTEIN, MD, Edward M P
150 East Eighth Street
Erie PA 16501
WARD, MD, Edgar H IM
104 E Second St
Erie PA 16507
WARDEN, MD, James R GS
316 W 23rd Street
Erie PA 16502
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Erie PA 16507
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WHARTON, MD, Stanley W EM
1950 Lakeside Dr
Erie PA 16511
WICKRAMASINGHE, MD, GP
Eardly K
3013 Contessa Ln
Erie PA 16506
WILHELM, MD, William C PD
104 E Second St
Erie PA 16507
WILKOS, MD, Francis J GP
619 E Tenth St
Erie PA 16503
WILLIAMS, MD, Richard A DR
104 E Second Street
Erie PA 16507
WITTMANN, MD, Thomas A PUD
2618 Sigsbee St
Erie PA 16508
WRIGHT, MD, Merja T EM
451 W Ninth St
Erie PA 16501
YOO, MD, Ho Joon DR
104 E Second St
Erie PA 16507
YOUNG, MD, Henry A GS
140 W Second St Ste 102
Erie PA 16507
YUN, MD, Jae K DR
232 W 25th St
Erie PA 16512
ZADEH, MD, Mehdi L GS
4520 Upland Dr
Erie PA 16509
ZEITLIN, MD, Mark H AN
506 W Arlington Rd
Erie PA 16509
ZIEZIULA, MD, Ronald F PD
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Erie PA 16507
ZIMM, MD, Edward J OTO
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Erie PA 16502
ZONE, MD, Donald D CD
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Masontown PA 15461
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R D 1
Smock PA 15480
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Uniontown PA 15401
COX, MD, Ralph L GP
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DAURIA, MD, Thomas M PD
205 Professional Plz
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121 Professional Plz
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Dubois Hosp 104 Hospital Ave
Dubois PA 15801
PARLAVECCHIO, MD, Dennis S FP
R D 1 Box 33 A-1
Penfield PA 15849
PATHAK, MD, Rajani K CD
145 Hospital Ave
Dubois PA 15801
RHOADES, DO, Dennis W FP
Six N Third St
Reynoldsville PA 15851
ROSCOE, MD, Gregory J OTO
23 Beaver Dr
Dubois PA 15801
SALDANA, MD, Idel J GP
R D 5 Med Arts Bldg
Punxsutawney PA 15767
SCERBO, MD, James A IM
C/O Maple Ave Hospital
Du Bois PA 15801
SCHAMP, MD, Richard O FP
216 Liberty Blvd
Dubois PA 15801
SCHULTZ, MD, Adrienne J FP
145 Hosp Ave Ste 205
Dubois PA 15801
SHAH, MD, Manjula S GYN
307 Greenridge Dr
Dubois PA 15801
SHAH, MD, Shirish N GS
307 Greenridge Dr
Dubois PA 15801
SIAR, MD, William J NPM
R D 1
Penfield PA 15849
SMITH, MD, Thomas W OPH
529 Sunflower Alley
Dubois PA 15801
SUVARNAKAR, MD, HEM
Jawahar N
118 Hospital Ave
Dubois PA 15801
THAMES, DO, Richard FP
105 W Mahoning St
Punxsutawney PA 15767
THOMAS, MD, Thomas K U
28 W Scribner Ave
Dubois PA 15801
TSAI, MD, Ming-Shang IM
105 W Mahoning St Ste 304
Punxsutawney PA 15767
VERONESI, DO, John N GP
Dubois Hosp E R
Dubois PA 15801
YOO, MD, Tai Y OBG
Dep Band Bldg Rm 234-236
Dubois PA 15801

LACKAWANNA

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1211 Wasburn St
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ANEJA, MD, Krishan K IM
Bank Tower Bldg Ste 429
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ANTOGNOLI, MD, William J PTH
403 Med Arts Bldg
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ARONICA, MD, Michael J PM
1609 Jefferson Ave
Dunmore PA 18512
ARORA, MD, Subhash C AN
746 Jefferson Ave
Scranton PA 18501
ARTABANE, MD, Thomas A IM
R D 2 Box 10
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BADAWI, MD, Radwan A D
822 Connell Bldg
Scranton PA 18503
BAJAJ, MD, Rajiv K AN
620 Carnation Dr
Clarks Summit PA 18411
BALDINO, MD, William A TS
401 Adams Ave
Scranton PA 18510
BANNON, MD, Charles J GS
743 Jefferson Ave
Scranton PA 18503
BARAKAT, MD, Adel R ORS
Medical Arts Bldg
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BARNES, MD, Willis C AN
311 Race St
West Pittston PA 18643
BARON JR, MD, Andrew J R
746 Jefferson Ave
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BATLUCK, DO, David J IM
Rd 5 Box 101
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Scranton PA 18505
BERARDIS, MD, Velio E GP
632 Prospect Ave
Scranton PA 18505
BERGER, MD, Norman S FP
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Scranton PA 18510
BERNSTEIN, MD, A Alexander GE
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BIANCA III, MD, Vincent C IM
P O Box 134
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Jessup PA 18434
BISIGNANI, MD, Gabriella M GP
946 Main St
Peckville PA 18452
BLACK JR, MD, William A NS
221 Lake Scranton Rd
Scranton PA 18505
BLOES, MD, Walter S GP
Five Washington Ave
Jermyn PA 18433
BLOMAIN, MD, E William OS
709 Main St
Avoca PA 18641
BLOMAIN, MD, Eric W PS
1222 Marion Street
Dunmore PA 18509
BOCCAGNO, MD, Phillip A IM
19-7 Hamilton Terrace
Clarks Summit PA 18411
BOLAND, MD, Francis P U
802 Jefferson St
Scranton PA 18510
BOLAND, MD, Stanley W OPH
Noble Rd
Clarks Summit PA 18411
BOLUS, MD, Charles M PS
Bank Towers Bldg
Scranton PA 18503
BORIOSI, MD, Guido D P
200 Penn Ave Ste 1
Scranton PA 18503
BOROWSKI, MD, Gregory D END
748 Quincy Ave
Scranton PA 18510
BRERETON, MD, Harmar D TR
Mercy Hosp
Scranton PA 18510
BRILL, MD, Francis W GP
1318 Jackson St
Scranton PA 18504
BROWN, MD, Sylvan RHU
201 Smallacombe Dr
Scranton PA 18508
BRUNDAGE, MD, John T GS
808 Pine St
Moscow PA 18444
BRUNDAGE, MD, Robert P GP
733 Main St
Peckville PA 18452

BRUTICO JR, MD, Carmen A IM
730 S Main St
Old Forge PA 18518
CACCIAMANI, MD, John D PUD
802 Jefferson Ave
Scranton PA 18510
CARINO, MD, Mariel G GP
204 Burton St
Peckville PA 18452
CASSONE, MD, Gary J U
427 Madison Ave
Scranton PA 18510
CECH, MD, Rosanne AI
748 Quincy Ave
Scranton PA 18510
CESARE, MD, Joseph G ORS
Medical Arts Bldg
Scranton PA 18503
CHAI, MD, Min S OBG
141 Salem Ave
Carbondale PA 18407
CHIAVACCI, MD, Wayne E PD
802 Jefferson Ave
Scranton PA 18510
CHUNG, MD, C Kun PS
802 Jefferson Avenue
Scranton, PA 18510
CIANNI, MD, Ronald J IM
722 Connell Bldg
Scranton PA 18501
CLAUSS, MD, Thomas F FP
515 George St
Throop PA 18512
COCHRAN, MD, Terence A GS
Madison Ave Med Ctr
Scranton PA 18501
COLEMAN, MD, Thomas H FP
76 N Main St
Carbondale PA 18407
COLLINS, MD, Clyde A GP
1735 Sanderson Ave
Scranton PA 18509
CONNORS, MD, Charles F FP
110 Potter St
Dunmore PA 18512
COTTONE, MD, Benjamin J US
403 Arthur Ave
Scranton PA 18510
CRAPARO, MD, Thomas J GP
101 Lincoln Ave
Carbondale PA 18407
CRONKEY, MD, Joseph E ORS
The Forum
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CROSS, MD, Albert J CD
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Tunkhannock PA 18657
CRUCIANI JR, MD, Dominick A OPH
304 Third Natl Bank Bldg
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CUPPLE, MD, Peter P P
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CURTIN, MD, Charles T PTH
403 Medical Arts Bldg
Scranton PA 18503
CURTIN, MD, Eugene A OBG
746 Jefferson Ave
Scranton PA 18501
DALY, MD, Jane HEM
201 Smallacomb Dr
Scranton PA 18508
DAVIS, MD, Harold J OBG
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Scranton PA 18510
DAVIS JR, MD, Robert V OPH
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DAWGERT, MD, F Dennis PD
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DELEHANTY, MD, Thomas J PUD
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Scranton PA 18510
DELEO, MD, Caesar A IM
748 Quincy Ave
Scranton PA 18510
DELEO, MD, Nicholas V GP
405 E Drinker St
Dunmore PA 18512
DEMKO, MD, Joseph N GER
919 Drinker St
Dunmore PA 18512
DEMPSEY, MD, James G GS
203 Franklin Ave
Scranton PA 18503
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R D 2 Box 13
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St Joseph Hosp
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Carbondale PA 18407
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Peckville PA 18452

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Dickson City PA 18519
DIAKIW, MD, John IM
748 Quincy Ave
Scranton PA 18510
DISILVIO, MD, Thomas V PTH
403 Medical Arts Bldg
Scranton PA 18503
DOHERTY JR, MD, John H ORS
746 Jefferson Ave
Scranton PA 18510
DOHERTY SR, MD, John H OBG
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DOVYDAITIS, MD, Romas DR
Mercy Hosp Xray
Scranton PA 18501
DRESSEL JR, MD, CD
Christopher J
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Scranton PA 18510
DRUFFNER, MD, Charles R IM
Scranton Life Bldg
Scranton PA 18503
DRUFFNER JR, MD, Lewis C GP
603 Grove St
Avoca PA 18641
DZIELAK, DO, Edward J IM
Moses Taylor Physicians Bldg
Scranton PA 18510
EAGEN, MD, Jeremiah W NEP
746 Jefferson Ave
Scranton PA 18510
EISNER, MD, Abraham G IM
Madison Ave At Pine St
Scranton PA 18510
FABI, MD, Mario N CD
746 Jefferson Ave
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Latlin PA 18702
FARRELL, MD, Robert E R
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Scranton PA 18503
FARRELL, MD, William J R
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FAVINI, MD, Josephine L GP
1610 Pittston Ave
Scranton PA 18505
FAVINI, MD, M Peter FP
1611 Pittston Ave
Scranton PA 18505
FAZIO, MD, Anthony N AN
746 Jefferson Ave
Scranton PA 18510
FERRARO, MD, Patrick J GS
201 Smallcombe Dr #202
Scranton PA 18508
FOGLEY, MD, Anees R IM
802 Jefferson Ave
Scranton PA 18510
FRANGOS, MD, James N R
746 Jefferson Avenue
Scranton PA 18501
FRATTALI, MD, August FP
100 N Main Ave
Scranton PA 18504
FROOZAN, MD, Homayoon N
201 Smallacombe Dr
Scranton PA 18508
FUREY, MD, Sandy A IM
748 Quincy Ave
Scranton PA 18510
GAFFNEY, MD, John J IM
310 George St
Throop PA 18512
GALLAGHER, MD, Michael J R
746 Jefferson Ave
Scranton PA 18501
GAREY, MD, Herman S OBG
1416 Monroe Ave
Scranton PA 18509
GAVIN, MD, J Robert FP
746 Jefferson Ave
Scranton PA 18510
GAZMEN, MD, Candonino C GS
117 Susquehanna Ave
Olyphant PA 18447
GENTILE, MD, Anthony J IM
748 Quincy Ave
Scranton PA 18510
GEORGIU, MD, Virgil OTO
70 Lincoln Ave
Carbondale PA 18407
GIOMBETTI, MD, Joseph J FP
201 Smallacombe Dr
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GOLDSTEIN, MD, Erroll J OBG
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GOLDSTEIN, MD, Milton J CD
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GOMBAR, MD, Edward F GP
522 Sanderson Ave
Scranton PA 18512
GOTTSHALL, MD, Samuel C AN
700 Quincy Ave
Scranton PA 18411
GRAD, MD, Charles T GE
201 Smallacombe Dr
Scranton PA 18508
GRATZ, MD, Richard E IM
115 River Ave
Olyphant PA 18447
GRYCZKO, MD, Gerald A ORS
743 Jefferson Ave 1st Fl
Scranton PA 18510
GUSTAITIS, MD, Joseph A GP
1642 N Main Ave
Scranton PA 18508
GUZEK, MD, John R IM
Madison Avenue & Pine Street
Scranton PA 18510
GUZEK, MD, Joseph T OPH
401 Adams Ave
Scranton PA 18510
HAHN, MD, Kon S OPH
141 Salem Ave
Carbondale PA 18407
HAMZAVI, MD, Siamak CDS
414 Madison Ave
Scranton PA 18510
HAN, MD, Sun Tak IM
746 Jefferson Ave
Scranton PA 18510
HANNA, MD, Raouf E PD
Connell Bldg
Scranton PA 18503
HARASYM, MD, Eugene D FP
201 Smallacombe Dr
Scranton PA 18508
HAZZOURI, MD, Michele A IM
426 Stafford Ave
Scranton PA 18505
HEIM, MD, William J HEM
743 Jefferson Ave 2nd Fl
Scranton PA 18510
HENNIGAN, MD, John J GER
404 S Main St
Old Forge PA 18518
HERSHFIELD, MD, David H OTO
417 Delaware Ave
Olyphant PA 18447
HIJAZI, MD, Saadeddine A GS
332 Northern Spy Rd
Clarks Summit PA 18411
HIPOLITO JR, MD, Emmanuel F IM
959 Wyoming
Scranton PA 18509
HOLLA, MD, P Shripathi NS
Bank Towers Ste 707
Scranton PA 18503
HOLLAND, MD, Sanford J AN
Moses Taylor Hosp An Dept
Scranton PA 18510
HOLMES, MD, John J GP
314 Rushbrook St
Jermyn PA 18433
HORCHOS, MD, Donald D PM
475 Morgan Hwy
Scranton PA 18508
HOWARD, MD, Lawrence J FP
746 Jefferson Ave
Scranton PA 18510
HUANG, MD, Chau Fe CD
201 Smallacombe Dr
Scranton PA 18508
HUBER, MD, Richard L FP
1112 Columbia St
Scranton PA 18509
HWAN, MD, Jung J OBG
319 N Abington Rd
Clarks Green PA 18411
ISAKOV, MD, Asparuh D AN
301 Gordon Dr
Clarks Summit PA 18411
JACOBS, MD, Kenneth M PUD
746 Jefferson Ave
Scranton PA 18501
JACOBSON, MD, Louise P
766 Bank Towers
Scranton PA 18503
JAN, MD, Tayyaba S PD
33 Park St
Carbondale PA 18407
JEWETT, MD, Stephen R FP
251 E Grove Ave
Clarks Summit PA 18411
JONES, MD, C Henry OPH
707 N Rebecca Ave
Scranton PA 18504
JORDAN, MD, Jerome W OPH
207 N Franklin Ave
Scranton PA 18503
JORDAN, MD, Wm J OPH
R D 6
Clarks Summit PA 18411

JORET, MD, Dale M OBG
401 Adams Ave Ste 300
Scranton PA 18510
JUNG, MD, Hong I GS
1416 Monroe Ave
Dunmore PA 18509
KACHLINE, DO, Donald A IM
240 Main St
Blakely PA 18447
KANE, MD, James A GS
743 Jefferson Ave
Scranton PA 18510
KAREHA, MD, Louis G GP
319 N Abington Rd
Clarks Summit PA 18411
KARUMBAYA, MD, Romola NS
Bank Towers #1117
Scranton PA 18503
KAUFMAN, MD, Benjamin V FP
650 N Main St
Taylor PA 18517
KEHRLI, MD, Henry J FP
313 S Main Ave
Scranton PA 18504
KEHRLI, MD, William H OPH
1536 N Washington Ave
Scranton PA 18509
KELLY, MD, Edward J R
212 Fairview Rd
Clarks Summit PA 18411
KEYES, MD, John W GP
R D 1
Jermyn PA 18433
KIRALY, MD, Laszlo GS
400 N Main Ave
Scranton PA 18504
KLINE, MD, Ben GP
111 S Turnpike Rd
Dalton PA 18414
KNELLER PHD EXEC, DIR, US
W Richard
1416 Monroe Ave Ste 301
Dunmore PA 18509
KOCH, MD, L Von CDS
401 Adams Ave #201
Scranton PA 18510
KONDASH, DO, Dennis J FP
Box 572
Waverly PA 18471
KRAFCHIN, MD, Ira C GS
1010 E Mountain Dr
Wilkes Barre PA 18702
KRAUSE, MD, Robert E OS
Marworth
Waverly PA 18471
KRISANDA, MD, Joseph B GP
112 Delaware Ave
Olyphant PA 18447
LALUNA, MD, Francis J ON
743 Jefferson Ave 2nd Fl
Scranton PA 18510
LAMBERTI, MD, William F P
748 Quincy Ave
Scranton PA 18510
LARKIN, MD, Frank L U
1320 College Ave
Scranton PA 18509
LARKIN, MD, Walter J OBG
327 W Market St
Scranton PA 18508
LARKIN JR, MD, Vincent D OS
Rd 3 Sugarbush Road
Dalton PA 18414
LARKIN JR, MD, Walter J OBG
401 Adams Ave Ste 300
Scranton PA 18510
LAWRENCE, MD, Salvatore A IM
108 E Drinker St
Dunmore PA 18512
LEE, MD, Edward Y CHP
1615 E Elm St
Scranton PA 18505
LEE, MD, Kyung C GS
1027 Pittston Ave
Scranton PA 18505
LEIMAN, MD, Paul M DR
746 Jefferson Ave
Scranton PA 18501
LESNIAK, MD, John P P
The Forum Plaza Penn Ave
Scranton PA 18503
LEVINSON, MD, Sander J PUD
746 Jefferson Ave
Scranton PA 18501
LILIK, MD, Kenneth W CHN
Bank Towers
Scranton PA 18503
LIM, MD, Michael K GS
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LINDHOLM, MD, Dale D NEP
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Scranton PA 18510
LIVECCHI, MD, John T OPH
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LOOMIS, MD, James W GP
1110 Saint Ann St
Scranton PA 18504
MACKRELL, MD, James J GS
401 Adams Ave
Scranton PA 18510

MACKRELL, MD, William P GP
Kennedy Dr
Archbald PA 18403
MADDEN, MD, Kevin G N
802 Jefferson Ave
Scranton PA 18510
MAIGUR, MD, William S GP
R D 4 Box 74-A
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MALLOY, MD, Edwin S ORS
233 Penn Ave
Scranton PA 18503
MARIANI, MD, Stephen S NM
746 Jefferson Ave
Scranton PA 18510
MARINO, MD, Joseph N FP
637 Prescott Ave
Scranton PA 18510
MARMO, MD, Theodore GP
121 Moosic Rd
Old Forge PA 18518
MASANKAY, MD, Manuel G GS
141 Salem Ave
Carbondale PA 18407
MCANDREW, MD, John J FP
319 Abington Rd
Clarks Summit PA 18411
MCANDREW, MD, Paul C IM
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St Petersburg FL 33701
MCDONALD, MD, Herbert M GS
622 Scranton Life Bldg
Scranton PA 18503
MCDONNELL, MD, Thomas J GP
306 Houston St
Clarks Summit PA 18411
MCGEEHAN, MD, John F IM
802 Jefferson Ave
Scranton PA 18510
MCGUIRE, MD, Edward J R
746 Jefferson Ave
Scranton PA 18501
MECCA, MD, Donato D OPH
101 Watres Dr
Scranton PA 18505
MENZEL, MD, Paul H IM
The Forum
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METZGER, MD, Paul C ORS
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METZGER, MD, Paul D FP
500 Old Colony Rd
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MILANI, MD, Frank A CD
201 Smallacombe Dr
Scranton PA 18508
MINORA, MD, Michael A GP
1714 Pittston Ave
Scranton PA 18505
MIRANDA, MD, Jorge U
140 Salem Ave
Carbondale PA 18407
MIZIN, MD, Lakshmi D J CD
165 Fallbrook St
Carbondale PA 18407
MOGERMAN, MD, Jeffrey A ORS
141 Salem Ave
Carbondale PA 18407
MOHAMED-ALI, MD, IM
Abul-Kassim
402 N Blakely Street
Dunmore PA 18512
MOORE, MD, Michael F GS
746 Jefferson Ave
Scranton PA 18510
MORGAN, MD, Albert P FP
403 First Natl Bank Bldg
Carbondale PA 18407
MORGAN JR, MD, Vernon W OBG
746 Jefferson Ave
Scranton PA 18510
MORI, MD, Gino GS
225 Penn Ave
Scranton PA 18503
MORI, MD, Hugo U
225 Penn Ave
Scranton PA 18503
MORITZ, MD, Mordekhai GE
Four Lakeside Dr
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MORRIS, MD, Adrian J IM
200 Main St
Blakely PA 18447
MOYLAN, MD, Joseph E FP
602 S Webster Ave
Scranton PA 18505
MOYLAN, MD, Robert E GP
812 N Sumner Ave
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MURPHY, MD, Louis R CD
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NATHAN, MD, Radha PD
1 Montgomery Viewmont Vlg
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NESE, MD, Anthony J GS
1008 Medical Arts Bldg
Scranton PA 18503
NEUMANN, MD, George L US
821 Vine St
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NEVILLE, MD, Edwin C TS
746 Jefferson Ave
Scranton PA 18510
NEWMAN III, MD, William H FP
251 E Grove Ave
Clarks Summit PA 18411
NEWTON, MD, Charles T N
701 Smallacombe Dr
Scranton PA 18508
NOTARI, MD, Edward J GP
201 Smallacombe Dr
Scranton PA 18508
NOURIAN, MD, Ali A P
706 Med Arts Bldg
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NOVEMBER, MD, Stephen R OBG
743 Jefferson Ave
Scranton PA 18501
OBOYLE, MD, James P OBG
2027 Green Ridge St
Scranton PA 18512
OBOYLE, MD, Tomas A PD
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OBRIEN, MD, Joseph J R
201 Med Arts Bldg
Scranton PA 18503
OCONNOR JR, MD, James J PTH
403 Med Arts Bldg
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ORAM, MD, Melvin FP
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PALANDJIAN, MD, CHP
Khatchadour B
141 Salem Ave
Carbondale PA 18407
PANCOAST, MD, Stephen J ID
R D 4 Box 326
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PARIKH, MD, Naresh CD
Forum Plaza-Penn Avenue
Scranton PA 18503
PARRILLO, MD, Douglas W R
746 Jefferson Ave
Scranton PA 18510
PARSICK, MD, Daniel P FP
399 N Ninth Ave
Scranton PA 18504
PASCUCCI, MD, Stephen E PD
Med Arts Bldg
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PATEL, MD, Bhupendra R P
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Mayfield PA 18433
PATEL, MD, Bipinchandra M CDS
Rd 2
Moscow PA 18444
PATEL, MD, Ramesh C OBG
141 Salem Ave
Carbondale PA 18407
PATRICK, MD, Nicholas E EM
Longview Terrace
Waverly PA 18471
PAVUK, MD, Daniel J OPH
Three Old Mill Rd
Jerwyn PA 18433
PELICCI, MD, Leroy J N
748 Quincy Ave
Scranton PA 18510
PERRY, MD, Anthony M IM
Med Arts Bldg Rm 609
Scranton PA 18503
PETERS, MD, John W PUD
802 Jefferson Ave
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PETTINATO, MD, Salvatore R GP
92 Salem Ave
Carbondale PA 18407
PHILBIN, MD, Joseph F IM
1736 Sanderson Ave
Scranton PA 18508
PICZON, MD, Oscar Y NEP
327 N Washington Ave Ste 603
Scranton PA 18503
PICZON, MD, Severino Y NS
Bank Towers Ste 1117
Scranton PA 18503
PLATT, MD, Howard A NS
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Scranton PA 18510
POLLINO, MD, Vincent FP
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Herminie PA 15637
POSSANZA, MD, Carl J IM
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Jessup PA 18434
POTELUNAS, MD, Clement B D
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PREATE, MD, Donald L U
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Scranton PA 18503
PRELI, MD, Olindo J CD
746 Jefferson Ave
Scranton PA 18510

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Dunmore PA 18510
RAMAKRISHNA, MD, IM
Srinivasarao
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RANCIER, MD, Lee F R
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RAO, MD, Madhava S CD
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REDEL, MD, Walter A GS
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Dalton PA 18414
REMICK, DO, Paul F FP
309 Sunnyside Ave
Clarks Summit PA 18411
RENNY, MD, Andrew GE
722 Connell Bldg
Scranton PA 18501
RHIEW, MD, Francis C DR
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Clarks Green PA 18411
ROBERTS JR, Douglas J R
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ROSENFELD, MD, Bernard D U
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Scranton PA 18503
ROSENTHAL, MD, Stephen I PD
720 N Webster Ave
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ROSIECKI, MD, Michael W OPH
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ROSS, MD, Vincent L PD
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ROSTOCK, MD, Robert A R
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RUDOLPH, MD, Kenneth H DIA
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Scranton PA 18510
RUGGIERO, DO, Dominic EM
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Med Arts Bldg Ste 606
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Scranton PA 18503
SCHEUER, MD, John W CD
713 Pittston Ave
Scranton PA 18505
SCHRECKENGAUST, MD, OBG
Robert H
746 Jefferson Ave
Scranton PA 18510
SCHUMAN, MD, Robert A R
327 N Washington Ave #201
Scranton PA 18503
SCIALLA, MD, Salvatore J HEM
743 Jefferson Ave 2nd Fl
Scranton PA 18510
SEBASTIANELLI, MD, Mario J IM
1416 Monroe Ave
Dunmore PA 18509
SEGAL, MD, Arthur M P
129 N Washington Ave
Scranton PA 18503
SEIGLE, MD, Walter E AN
745 N Webster Ave
Scranton PA 18510
SERINE, MD, Enrico A IM
201 Smallacomber Dr
Scranton PA 18508
SHAH, MD, Rahmat AN
Box 555
Waverly PA 18471

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748 Quincy Ave
Scranton PA 18510
SHANDER, MD, Ernest G AN
1107 Richmont St
Scranton PA 18509
SHARMA, MD, Meera V RHU
Third Fl Bank Towers Bldg
Scranton PA 18503
SHEER, MD, George W DR
327 N Washington Ave #201-6
Scranton PA 18503
SHELDON, MD, Douglas L D
Bank Towers Bldg 4Th Fl
Scranton PA 18503
SHELLMAN, MD, Alexander ORS
513 W Lackawanna Ave
Olyphant PA 18447
SHINGALA, MD, Arun J CD
141 Salem Ave
Carbondale PA 18407
SHOVLIN, MD, John M P
55 Laurel St
Carbondale PA 18407
SHYNN, MD, Tae I P
111 Sturbridge Rd
Clarks Summit PA 18411
SIBLEY, MD, Robert E DR
120 Overlook Road
Clarks Summit PA 18411
SIMPSON, MD, Roy W GP
304 Chestnut St
Peckville PA 18452
SINGH, MD, Arvind K AN
1010 Sleepy Hollow Rd
Clarks Summit PA 18411
SINNENBERG JR, MD, PTH
Robert J
403 Medical Arts Bldg
Scranton PA 18414
SIROTNAK, MD, John J OTO
310 Dunmore St
Throop PA 18512
SKETTINO, MD, Joseph A OPH
401 Adams Ave
Scranton PA 18510
SKOVIRA, MD, Edward M PTH
217 Hand St
Jessup PA 18434
SLOVAK, MD, James P P
Bank Towers
Scranton PA 18503
SMOLKO, MD, Milan J U
802 Jefferson Ave
Scranton PA 18510
SNYDER, MD, Randall W GE
201 Smallacombe Dr
Scranton PA 18508
SOMA, MD, Joseph J AI
201 Smallacombe Dr
Scranton PA 18508
STEC, MD, Eugene G FP
203 Oakford Rd
Clarks Summit PA 18411
STEINBACH III, MD, William A ORS
233 Penn Ave
Scranton PA 18503
STEINDEL, MD, Carl R ORS
233 Penn Ave
Scranton PA 18503
STELLA, MD, Joseph E FP
201 Smallacombe Dr
Scranton PA 18508
STEWART, MD, Michael P GS
225 Penn Ave
Scranton PA 18503
SU, MD, Lang-Pao AN
144 Main St
Peckville PA 18452
SUH, MD, Sang J GS
166 N Main St
Old Forge PA 18518
SULLUM, MD, Jonathan C DR
201 Medical Arts Bldg
Scranton PA 18503
SUNDHEIM, MD, James L DR
Moses Taylor Hosp Dept Of Rad
Scranton PA 18510
SWIFT, MD, Frank L PD
1510 N Washington Ave
Scranton PA 18509
TAN, MD, Edwin L P
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Scranton PA 18510
THOMPSON, MD, Carson J NS
Mercy Hosp
Scranton PA 18501
THORNTON, MD, Eva A P
V A Hosp
Wilkes Barre PA 18702
TODARO, MD, Samuel R ORS
746 Jefferson Ave 1st Fl
Scranton PA 18510
TOMAZIC, DO, David R FP
632 Main St
Forest City PA 18421
TOUCH, MD, Ralph J GP
48 Garfield Ave
Carbondale PA 18407
TRACY, MD, Gerald P CD
746 Jefferson Avenue
Scranton PA 18510

TUAN, MD, Bao-Kuen FP
414 Madison Avenue
Scranton PA 18510
TUROCK, MD, Michael J FP
397 N Ninth Street
Scranton PA 18504
UDOMSAK, MD, Paramin GS
1027 Pittston Ave
Scranton PA 18518
UROSKIE, MD, Theodore W OBG
200 Yale Blvd
Clarks Summit PA 18411
VALVERDE, MD, Mario F OPH
812 Scranton Life Bldg
Scranton PA 18503
VENTRE, MD, Susan PD
146 N Main St
Old Forge PA 18518
VENTURA, MD, Cecilia R PD
119 Main St
Blakely PA 18447
VENTURA, MD, Samuel R OBG
119 Main St
Blakely PA 18447
VILLASIN, MD, Joseph V PTH
64 Locust St
Wilkes Barre PA 18702
VITALE, MD, Louis J CHP
537 Venard Rd
Clarks Summit PA 18411
WAGNER, MD, John M IM
112 Colborn Ave
Clarks Summit PA 18411
WAIBEL, MD, David A IM
Timberfalls At Blakely
Blakely PA 18447
WALLER, MD, Louis C IM
140 Cherry St
Dunmore PA 18512
WALNISTA, MD, Frank J GP
222 Oak St
Scranton PA 18508
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Clarks Green PA 18411
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WU, MD, Jung-Yi GS
302 Harrison Ave
Scranton PA 18510
YEAGER, MD, Henry C IM
746 Jefferson Ave
Scranton PA 18510
YEVITZ, MD, Michael G GP
624 Connell Bldg
Scranton PA 18503
YEVITZ, MD, William J GP
1514 Madison Ave
Scranton PA 18509
YOO, MD, Eun S P
R D 1 Golf Hill Rd
Homesdale PA 18431
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Scranton PA 18509
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1601 Madison Avenue
Dunmore PA 18512
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ALBRECHT, MD, James B FP
676 E Main St
New Holland PA 17557
ALBRIGHT, MD, Gerald S GP
241 Main St
Landisville PA 17538
ALTIMARE, MD, Peter J FP
951 W Walnut St
Lancaster PA 17603
ALTMAN JR, MD, Richard S GE
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Lancaster PA 17602
AMEND, MD, Thomas C GP
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Lancaster PA 17602
ANDERSEN, MD, Thomas W FP
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ANNESE, DO, Joseph S OTO
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Lancaster PA 17601
ARGIRES, MD, James P NS
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ATLEE, MD, William A GS
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AXELROD, DO, Norman M GS
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BACHMAN, MD, William H FP
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BACON, MD, Richard W FP
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BAIR, MD, Charles W GP
22 W State St
Quarryville PA 17566
BAIRD, MD, Edward F AN
St Joseph Hospital
Lancaster PA 17604
BAIRD, MD, Robert J FP
Manor Family Health Center
Millersville PA 17551
BAKKEN, MD, William W FP
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Lancaster PA 17603
BALIKIAN, MD, Manuel IM
102 Fox Run Circle
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BALKANY, MD, Christopher K IM
202 Butler Ave
Lancaster PA 17601
BARR, MD, V Ward NS
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Lancaster PA 17601
BARTGES, MD, John D U
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BASHORE JR, MD, Robert M OBG
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Lancaster PA 17602
BEACHER JR, MD, George W GP
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Gap PA 17527
BECKER, MD, Hilary J PD
800 Estelle Dr
Lancaster PA 17601
BEITTEL, MD, James P PD
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Lancaster PA 17601
BENDER, MD, Robert R GP
Bowmansville PA 17507
BERING, MD, Thomas G AN
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Lancaster PA 17602
BERNHARD, MD, Robert A R
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BESECKER, MD, Joseph A PD
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BIEBER, MD, Larien G IM
1950 Marietta Ave
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BONCHEK, MD, Lawrence I CDS
555 N Duke Street
Lancaster PA 17603
BOWERS, MD, David W FP
562 W Second Avenue
Lititz PA 17543
BOWMAN, MD, John H OPH
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BRANAS, DO, John A GP
2158 Fruitville Pk
Lancaster PA 17601
BRESLIN, MD, Joseph A U
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BREWER, MD, Robert H FP
Rt 441 & Bank St
Marietta PA 17547
BROWN, MD, H Zane OPH
1254 Lititz Pk
Lancaster PA 17601
BROWN, MD, Robert E AN
1244 Hunsicker Rd
Lancaster PA 17602
BRUBAKER, MD, J Kenneth FP
Norlanco Med Assoc
Elizabethtown PA 17022
BRUBAKER, MD, Jacob H GP
421 Main St
Denver PA 17517
BRUBAKER, MD, Paul E FP
Norlanco Med Assoc
Elizabethtown PA 17022
BRYSON, MD, Richard L GP
120 Bank St
Landisville PA 17538
BUCH, MD, Robert R GP
125 W Main St
Mountville PA 17554
BURLINGAME, MD, Mark W CDS
555 N Duke St
Lancaster PA 17602
BURNETT, MD, George W PD
225 N President Ave
Lancaster PA 17603
BUSKO, MD, Carlton W GP
1810 Rothsville Road
Lititz PA 17543
CALKINS, MD, Joseph L OPH
202 Butler Ave
Lancaster PA 17601
CAPPIELLO, MD, Justin L OPH
324 N Duke St
Lancaster PA 17602
CARROLL, MD, Laurence E NEP
33 Wythe Cir
Lancaster PA 17601
CARRUTHERS, MD, Ralph B GP
211 N Eighth St
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CARTER, MD, William A FP
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Lancaster PA 17602
CLELAN, MD, George M AN
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Lancaster PA 17602
COLLURA, MD, Paul T DR
602 Northlawn Drive
Lancaster PA 17604
CONDRON, MD, Brian P P
1295 Meadowbrook Rd
Lancaster PA 17603
CONNAUGHTON, MD, Patrick N DR
555 N Duke St
Lancaster PA 17604
CONRAD, MD, Wayne R ORS
527 N Lime St
Lancaster PA 17602
COOKE JR, MD, Alfred J ORS
127 E Frederick St
Lancaster PA 17602
COOPER, MD, Emmett M NM
1370 Hunter Dr
Lancaster PA 17601
COOPER III, MD, Herbert K P
229 W Woods Dr
Lititz PA 17543
COOPER JR, MD, Herbert K DIA
202 Butler Ave
Lancaster PA 17601
COOPERSTEIN, DO, Mark S GP
2183 Oregon Pike
Lancaster PA 17601
CORCORAN, MD, John J OBG
1887 Lititz Pk
Lancaster PA 17601
COURSIN, MD, David B PD
1503 Hillcrest Rd
Lancaster PA 17603
CRANDALL III, MD, Richard A FP
247 Main St
Landisville PA 17538
CRILL, MD, Norman C GP
143 Millersville Rd
Lancaster PA 17603
CRYSTLE, MD, C Deans OBG
162 Hamilton Rd
Lancaster PA 17603
DALEY, MD, Marvin C U
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Lancaster PA 17603
DAMATO, MD, Samuel L DR
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Ephrata PA 17522
DAVIDSON, MD, Paul R GS
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Lancaster PA 17601
DAVIS, MD, Allan S HEM
333 N Arch Street
Lancaster PA 17603
DAVIS, MD, Irene B OBG
70 Peach La
Lancaster PA 17601
DEARDORFF, MD, Charles L GS
822 Marietta Ave
Lancaster PA 17603
DEGREEN, MD, Hyatt P ON
333 N Arch Street
Lancaster PA 17603
DENLINGER, MD, John K AN
1440 Country Club Dr
Lancaster PA 17601
DERR, MD, Russell H US
154 W Main St
Adamstown PA 19501
DIAMANTONI, MD, Stephen G FP
604 N Plum St
Lancaster PA 17602
DIEHL, MD, Daniel L FP
225 Millwood Road
Lancaster PA 17602
DOE, MD, Robert G FP
213 Tomahawk Dr E
Conestoga PA 17516
DOENECKE, MD, Arthur L GP
443 N Duke Street
Lancaster PA 17602
DORAZIO, MD, Dominick J AN
133 E Frederick St
Lancaster PA 17602
DRAGANN, DO, Raymond D ORS
703 Lampeter Rd
Lancaster PA 17602
DUPREY, MD, James G FP
181 Conestoga Blvd
Lancaster PA 17602
EASTMAN III, MD, James T CLP
32 Bentley Summit
Lancaster PA 17603
EBERSOLE, MD, John H TR
Lancaster Gen Hosp
Lancaster PA 17604
ECKENRODE, MD, Joseph L GP
834 Marietta Ave
Lancaster PA 17603
EISENHOWER, MD, Edward A PTH
613 Heather Lane
Lancaster PA 17603
ELLISON, MD, Ervin OM
815 Wilson Dr
Lancaster PA 17603
ENGLE, MD, Eugene K FP
130 S Penn St
Manheim PA 17545
ESBENSHADE II, MD, John H IM
445 N Duke St
Lancaster PA 17602
ESHLEMAN, MD, D Rohrer EM
985 Nissley Rd
Lancaster PA 17601
ESHLEMAN, MD, John D PUD
Lancaster Gen Hosp
Lancaster PA 17604
ESHLEMAN, MD, S Kendrick P
317 N Duke St
Lancaster PA 17602
ETNOYER, MD, John J OBG
549 N Lime St
Lancaster PA 17602
EVANS, MD, Charles M ORS
301 W Main St Box 512
Ephrata PA 17522
EYLER, MD, Paul W R
1332 Hillcrest Rd
Lancaster PA 17603
FALK JR, MD, Robert B AN
133 E Frederick St
Lancaster PA 17602
FARMER, MD, John L GS
1140 Columbia Ave
Lancaster PA 17603
FEEHAN, MD, Patrick R D
1903 Lititz Pk
Lancaster PA 17601
FERGUSON, MD, Robert H N
127 Waterfront Estates Drive
Lancaster PA 17602
FLEISCHER, MD, Leslie R CD
250 College Ave Box 3509
Lancaster PA 17604
FLORES, MD, Alberto C IM
3413 Goshen Rd
Newtown Square PA 19073
FORMAN, MD, Irwin H P
342 College Ave
Lancaster PA 17603
FOUST, MD, Wilson A GP
592 E Valley View Dr
New Holland PA 17557
FRANCE, MD, Laurence W OBG
1059 Columbia Ave
Lancaster PA 17603
FREDERICK, MD, David W FP
101 Abbeyville Rd
Lancaster PA 17603
FUCHS, MD, David E FP
3045 Marietta Avenue
Lancaster PA 17603
FULTON, MD, Harry C OPH
1420 Hunsicker Rd
Lancaster PA 17601
GALANIS, MD, Sotire E ORS
884 N Maple St
Ephrata PA 17522
GAREIS, MD, John W R
2101 Millersville Pk
Lancaster PA 17603
GAROFOLA, MD, John H R
Lancaster General Hosp
Lancaster PA 17604
GARRIDO, MD, Eddy NS
1671 Crooked Oak Dr
Lancaster PA 17601
GARVEY, MD, Edmund P AN
401 Chowning Place
Lancaster PA 17601
GASTALDO, MD, John A NS
299 Hess Blvd
Lancaster PA 17601
GAULT, MD, James H CD
420 W Chestnut St
Lancaster PA 17603
GAUSE, MD, Paul E IM
P O Box 419
Ephrata PA 17522
GAYESKI, MD, Richard J FP
16-A Manor Ave
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GAYNOR, MD, William B PTH
23 Ridge Dr
Lititz PA 17543
GENTZLER II, MD, Richard D CD
420 W Chestnut St
Lancaster PA 17603
GEORGE, MD, Ellen M FP
Lancaster Gen Hosp-Dept Fp
Lancaster PA 17603
GIVLER JR, MD, Donald N FP
2826 Spring Valley Rd
Lancaster PA 17601
GLAH JR, MD, Henry J OS
906 E Orange St
Lancaster PA 17602
GODDARD JR, MD, James E AN
1311 Hunter Dr
Lancaster PA 17601
GODSHALL, MD, Stanley M FP
Norlanco Med Assoc
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GOLDIN, MD, Ralph J GP
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GOLDMAN, MD, Duane C R
630 Millcross Rd
Lancaster PA 17601
GOLDMAN, MD, Gary L AN
403 Wetherburn Drive
Lancaster PA 17601
GOOD, MD, Daniel C NS
1671 Crooked Oak Dr
Lancaster PA 17601
GOOD, MD, Milton S FP
610 Highlawn Ave
Elizabethtown PA 17022
GOTTLIEB, MD, Jerome I P
330 N Duke Street
Lancaster PA 17602
GOTTLIEB, MD, Robert J ON
1875 Lititz Pk
Lancaster PA 17601
GRANT, MD, Alistair M OBG
549 N Lime St
Lancaster PA 17602
GRASSE JR, MD, John M GP
115 N Nineth St
Akron PA 17501
GRAY, MD, Louis P FP
647 E Roseville Rd
Lancaster PA 17601
GREENE, MD, Neil A ID
24 E James St
Lancaster PA 17602
GRISWOLD, MD, Arthur S GP
402 S Broad St
Lititz PA 17543
GROSH, MD, John L IM
1875 Lititz Pk
Lancaster PA 17601
GROSH, MD, Joseph W GP
2 S Broad St
Lititz PA 17543
GROSH, MD, Paul R IM
1521 Ridge Rd
Lancaster PA 17603
GROSH, MD, William B FP
Two S Broad St
Lititz PA 17543
GROSH, MD, William K FP
1036 Broad St
Akron PA 17501
GSCHWEND III, MD, Paul GS
822 Marietta Ave
Lancaster PA 17603
HACKMAN, MD, Vicki L FP
316 Harvestview N
Mount Joy PA 17552
HALPERN, MD, Barton L OPH
175 Delp Rd
Lancaster PA 17601
HAMMOND, MD, Charles P GP
449 W James St
Lancaster PA 17603
HARGRAVE, MD, Hugh J AN
133 E Frederick
Lancaster PA 17602
HARNISH, MD, David M GS
208 W Main St
Ephrata PA 17522
HARRIGER, MD, Miles D GP
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HARRISON, MD, Cynthia EM
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HARTMAN, MD, William F OBG
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HASSEL JR, MD, Carl W D
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HAUCK, MD, Samuel M CD
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JOHNSON JR, MD, Bertram L CD
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Lancaster PA 17603
JOHNSTON, MD, Eugene V GP
20 Pine St
Christiana PA 17509
JONES, MD, Julie L FP
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Lancaster PA 17603
JONES, MD, Terrence H FP
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Manheim PA 17545
JONES JR, MD, Arthur F OTO
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KATZ, MD, Joseph AN
275 Blossom Hill Dr
Lancaster PA 17601
KAUR, MD, Manjeet PD
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Lancaster PA 17603
KEARNS, MD, Joseph W EM
313 W Oak St
Palmyra PA 17078
KEEFE, MD, Jerry M FP
96 Highland Ave
Ephrata PA 17522
KEGEL, MD, Daniel P OBG
1059 Columbia Ave
Lancaster PA 17603
KEGEL, MD, Eugene E OBG
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Lancaster PA 17602
KENDALL, MD, Leigh W GS
1314 Quarry Ln
Lancaster PA 17603
KENNA, MD, Jos Patrick EM
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Lancaster PA 17601
KENT, MD, George M ORS
325 N Duke St
Lancaster PA 17602
KIM, MD, Achin PDA
2445 Marietta Ave
Lancaster PA 17601
KIM, MD, Hack J IM
3244 Harrisburg Pk
Landisville PA 17538
KIM, MD, Yong Won OBG
1081 Swipe Ln
Ephrata PA 17522
KINTZI, MD, Harry E EM
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KIPP, MD, James E FP
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Lancaster PA 17602
KIRK, MD, Marvel S GP
446 W Chestnut St
Lancaster PA 17603
KIRK, MD, Norris J GS
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Lancaster PA 17603
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KNERR JR, MD, Edgar D GYN
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Paradise PA 17562
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Lebanon PA 17042
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711 S Eighth St
Lebanon PA 17042
CLEMENS, MD, Thomas M CD
315 Hathaway Park
Lebanon PA 17042
CONNER, MD, George H OTO
M S Hershey Med Ctr
Hershey PA 17033
COOPEY, MD, Frederick D OTO
1570 Cornwall Road
Lebanon PA 17402
COURTNEY, MD, Drew E FP
R D 3
Myerstown PA 17067
CURANZY, MD, Raymond R FP
39 E Maple St
Palmyra PA 17078
DAVIDSON JR, MD, William R IM
618 Cornwall Rd
Lebanon PA 17042
DIEHL, MD, William H OTO
Moravian Manor
Lititz PA 17543
DIGIACOMO, MD, Paul R CD
315 Hathaway Park
Lebanon PA 17042
DINULOS, MD, Baltazar T GS
225 S Fourth St
Lebanon PA 17042
DORSCH JR, MD, Raymond M ORS
229 S Fourth St
Lebanon PA 17042
DRUCKMAN, MD, Stephen M IM
315 Hathaway Park
Lebanon PA 17042
DYREYES, MD, Roberto R R
1647 Cambridge Dr
Lebanon PA 17042

EARLY, MD, Robert F GP
Third & Oak Streets
Lebanon PA 17042
ECKROTH, MD, Richard N GP
136 E Cherry St
Palmyra PA 17078
ELLIS, MD, David W IM
32 S Second St
Wormleysburg PA 17043
ENGLE, MD, Harold H FP
322 E Main St
Palmyra PA 17078
FAVA, MD, George E OPH
1524 Elm St
Lebanon PA 17042
FLOWERS, MD, Peter B FP
618 Cornwall Rd
Lebanon PA 17042
FOLTZ EXEC, SEC, Ms Susan US
Good Samaritan Hosp
Lebanon PA 17042
FORKER, MD, Thomas ORS
247 Cedar Ave
Hershey PA 17033
FRANK, MD, Patrick J GP
925 Cumberland St
Lebanon PA 17042
GINGRICH, MD, Kerry H GP
618 Cornwall Rd
Lebanon PA 17042
GINGRICH JR, MD, Russell L GP
34 N Center Ave
Cleona PA 17042
GORDON, MD, Robert A IM
618 Cornwall Rd
Lebanon PA 17042
GROH, MD, John R EM
1835 Mill Rd
Lebanon PA 17042
GROSKY, MD, Murray B END
315 Hathaway Park
Lebanon PA 17042
HABECKER, MD, Elizabeth T PD
1654 Rita Ln
Lebanon PA 17042
HALLAHAN, MD, William F CD
618 Cornwall Rd
Lebanon PA 17042
HARRISON, MD, Timothy S GS
M S Hershey Med Ctr
Hershey PA 17033
HARTMAN II, MD, Samuel A PD
Plaza Apts
Lebanon PA 17042
HAUER, MD, Marlin L GP
330 Cumberland St
Lebanon PA 17042
HEBERLING, MD, Thomas P EM
601 S 12th St
Lebanon PA 17042
HEISEY, MD, Robert G OBG
Third & Willow Streets
Lebanon PA 17042
HIRSCH, MD, Glenn M FP
700 E Main St
Annville PA 17003
HOFFMAN, MD, Glenn H FP
629 W Pine St
Palmyra PA 17078
HOFFMAN, MD, Richard R R
1149 Greiner St
Lebanon PA 17042
HOSTETTER, MD, Abram M P
20 Briarcrest Sq
Hershey PA 17033
JONES, MD, Edward GS
422 Cumberland St
Lebanon PA 17042
KASALES, MD, Clarence J U
41 Foxanna Dr
Hershey PA 17033
KEITER, MD, James M EM
30 W Orchard Dr
Palmyra PA 17078
KLATCHKO, MD, William W GS
402 S 12th St
Lebanon PA 17042
KLINE, MD, Robert M GP
115 E Walnut St
Lebanon PA 17042
KREIDER, MD, Edward E AN
502 Village Of Timbercreek
Lindenwood NJ 08021
LAPE JR, MD, I Samuel US
Third & Willow Sts
Lebanon PA 17042
LIGHT, MD, John J B IM
25 N Nineth St
Lebanon PA 17042
LONG, MD, Theodore K OPH
1660 Fieldcrest Rd
Lebanon PA 17042
MARKS, DO, Burton R
Gsh Fourth & Walnut Sts
Lebanon PA 17042
MARRONE, MD, Michael S FP
101 W Cherry St
Palmyra PA 17078
MARTIN, MD, Donald E AN
19 Gentry Dr
Palmyra PA 17078
MEYER JR, MD, Maurice M OPH
701 Maple St
Lebanon PA 17042
MILLER, MD, Carl S PM
R D 2 Box 2601
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1151 Cornwall Rd
Lebanon PA 17042
MORASCO, MD, Edward R GP
102 E Penn Ave
Cleona PA 17042
MORRIS JR, DO, Wilson S PUD
Hathaway Park At Fourth St
Lebanon PA 17042
MYSTAKAS, MD, Fotis G ORS
235 N Zinns Mill Road
Lebanon PA 17042
NEFF, MD, Charles A P
283 S Butler Rd
Lebanon PA 17042
NIELSEN, MD, Robert K FP
700 E Main St
Annville PA 17003
NUCUM, MD, Afrodisio N GP
1311 Elm Street
Lebanon PA 17042
OH, MD, Chang W OBG
618 Cornwall Road
Lebanon PA 17042
PASTOR, MD, James A AN
P O Box 1176
Lebanon PA 17042
PATERNITI, MD, Samuel F OBG
Third & Willow Sts
Lebanon PA 17042
PLACE, MD, Elmer R GP
111 Park St
Lebanon PA 17042
POTASH, MD, George C OPH
513 Chestnut St
Lebanon PA 17042
POUST, MD, George S OBG
Third & Willow Sts
Lebanon PA 17042
PROVENCIO, MD, Florencio PTH
1661 Krim Ct
Lebanon PA 17042
RIM, MD, Jeung K IM
59 Walden Rd
Lebanon PA 17042
ROLLO, MD, Daniel P OBG
151 Maple Lane
Lebanon PA 17042
SACKS, MD, Richard P R
R D 3
Manheim PA 17545
SAYSON, MD, Jose N IM
302 Walnut St
Lebanon PA 17042
SCHAEFFER JR, MD, William E IM
618 Cornwall Rd
Lebanon PA 17042
SCHREIBER, MD, Richard D GP
801 Walnut St
Lebanon PA 17042
SILBERMAN, MD, J Dewolf OPH
1552 Rita Ln
Lebanon PA 17042
SNYDER, MD, Diehl M P
Philhaven Hosp
Mount Gretna PA 17064
SNYDER, MD, Earl J GS
Fourth St & Hathaway Park
Lebanon PA 17042
SNYDER, MD, Harvey B IM
1151 Nowlen St
Lebanon PA 17042
SOLOMON, MD, Stephen J N
618 Cornwall Rd
Lebanon PA 17042
SOMMERVILLE, MD, Kenneth W N
Fourth St & Hathaway Park
Lebanon PA 17042
SPOTTS, MD, Ricke L FP
700 E Main St
Annville PA 17003
SRUR, MD, Jimmy S ORS
229 S Fourth St
Lebanon PA 17042
STOUTENBOROUGH, MD, IM
Kenneth A
Hathaway Park At Fourth
Lebanon PA 17042
SUAREZ, MD, Ramon U U
1023 Poplar St
Lebanon PA 17042
SUTER, MD, Stanley C U
1023 Poplar St
Lebanon PA 17042
SZYDLOWSKI, MD, Thaddeus R IM
618 Cornwall Rd
Lebanon PA 17042
TANNER, MD, Leonard M PTH
1551 Rita Ln
Lebanon PA 17042
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523 N Seventh St
Lebanon PA 17042
UHRICH, MD, Robert W US
523 N Seventh St
Lebanon PA 17042
VISWANATHAN, MD, Byravan IM
1421 Cornwall Rd
Lebanon PA 17042
WALMER, MD, John D P
Philhaven 283 S Butler Rd
Lebanon PA 17042
WEYLAND, MD, Charletta K PD
209 Hathaway Park
Lebanon PA 17042
WHEELER, MD, Glen N GP
199 Walnut St
Lebanon PA 17042
WINER, MD, Stephen F GS
225 Royal Rd
Lebanon PA 17042
WORRILOW, MD, Suzanne H GP
400 E High St
Lebanon PA 17042
YEAMANS, MD, Bruce E FP
21 School Ln
Lebanon PA 17042
YOCUM, DO, Jeffrey A GP
940 Cumberland St
Lebanon PA 17042
YOCUM, DO, Martin D US
404 Park Dr
Lebanon PA 17042
YUN, MD, Won K OBG
618 Cornwall Rd
Lebanon PA 17042
ZIMMERMAN JR, MD, Franklin D GP
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ZINSSER, MD, Kendall R PTH
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Catasaqua PA 18032
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Allentown PA 18102
ANDERKO, MD, Frank T GP
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ARANGIO, MD, George A ORS
32 N West St
Allentown PA 18102
ASNANI, MD, Mithlesh G PD
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BARILLA, MD, Donald E END
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Allentown PA 18104
BARNES, MD, Ben C IM
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Stone Harbor NJ 08247
BARONE, MD, Anthony AN
421 Chew Street 4-B
Allentown PA 18102
BARR, MD, William B GE
White Acre Dr North R D 5
Bethlehem PA 18015
BARRETT, MD, Judith N FP
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C/O J Peter Becker
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1624 Walnut St
Allentown PA 18102
BAUSCH, MD, Richard D FP
951 N Fourth St
Allentown PA 18102
BAUSCH JR, MD, Frederick R GP
142 N Nineth St
Allentown PA 18102
BAYRI, MD, Mehmet F AN
1196 W Meadowbrook Cir
Allentown PA 18103
BEITEL JR, MD, Robert J OPH
1026 Hamilton St
Allentown PA 18101
BENZEL, MD, Stanley R
315 N 27th St
Allentown PA 18104
BERGER, MD, Alan GS
1251 S Cedar Crest Blvd
Allentown PA 18103
BERNHARD, MD, John J OBG
421 Luther Crest
Allentown PA 18104
BIERMAN, MD, Joseph R GP
1321 Hamilton St
Allentown PA 18102
BLAISDELL, MD, C Theodore AN
421 Chew St C-3
Allentown PA 18102
BLAKE, MD, Douglas R AN
421 Chew Street 4-B
Allentown PA 18102
BLINDER, MD, Jeffrey S DR
918 N 25th St
Allentown PA 18104
BONEKEMPER, MD, Thomas W IM
R D 5 Box 199
Quakertown PA 18951
BONOS III, MD, Charles T EM
Lehigh Valley Hosp Dept Of Em
Allentown PA 18105
BOO, MD, Ki T IM
815 N 12th St
Allentown PA 18102
BOUCHER, MD, William F FP
234 E 20th St
Northampton PA 18067
BOWEN, MD, Dale T FP
1136 Fifth St
Catasauqua PA 18032
BOYER, MD, George S GS
740 N 19th St
Allentown PA 18104
BRANTON, MD, Leon N PD
811 N 19th St
Allentown PA 18104
BREN, DO, Deborah A OS
826 S 12th Street Apt 8
Allentown PA 18103
BRENNEN, MD, Robert F GP
951 N Fourth St
Allentown PA 18102
BROOKS, MD, Charles M GE
1462 Wedgewood Rd
Allentown PA 18104
BROSSMAN, MD, Martin W GP
P O Box 4
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BROWN, MD, Christopher L DR
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Emmaus PA 18049
BUCHANAN IV, MD, Harry W OPH
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Allentown PA 18104
BUCKLEY, MD, Ronald J FP
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1888 W Brookhaven Dr
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BURKHOLDER, MD, Thomas O OPH
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Allentown PA 18104
BUSCH, MD, Michael F ORS
1210 S Cedar Crest Blvd
Allentown PA 18103
CACCESE, MD, David M IM
401 N 17th Street #201
Allentown PA 18104
CAMPOS, MD, Luis I GS
421 Chew Street 2-B
Allentown PA 18102
CANDIO, MD, Joseph A IM
1251 S Cedar Crest Blvd
Allentown PA 18103
CARAPELLA, MD, John D GP
13 Lone Ln
Allentown PA 18104
CARBAUGH, MD, Howard L GP
614 N Sixth St
Allentown PA 18102
CARNEY, MD, David P IM
2532 Washington St
Allentown PA 18104
CARPENTER IV, MD, E Joel GP
102 N 13th St
Allentown PA 18102
CASSEL, MD, John J CD
1259 S Cedar Crest Blvd
Allentown PA 18103
CERCIELLO, MD, Mark J ORS
40 S Cedar Crest Blvd
Allentown PA 18104
CHANG, MD, In-Ho AN
Allentown Hosp
Allentown PA 18102
CHEN, MD, Juh-Huey PD
Box 80
Trexlertown PA 18087
CHENG, MD, Harvey S OPH
2710 Liberty St
Allentown PA 18104
CHENG, MD, Lawrence C GP
2710 Liberty St
Allentown PA 18104
CHILD, MD, Proctor L PTH
1819 Saratoga Ct
Allentown PA 18104
CHURCH, MD, Paul A U
1111 N 19th St
Allentown PA 18104
CRISWELL, MD, Samuel W FP
533 N 26th St
Allentown PA 18104
CRUZ, MD, Edgardo S AN
3101 Trexler Blvd
Allentown PA 18104
CUSTODIO, MD, Edgardo C DR
785 Wedgewood Rd
Bethlehem PA 18017
DANGELO, MD, Carl F GE
401 N 17th Street #207
Allentown PA 18104
DEEB, MD, Ramon J AN
1627 Chew St Ste 1310
Allentown PA 18102
DESHPANDE, MD, Vilas K PD
811 N 19th St
Allentown PA 18104
DEX, MD, Walter J DR
Allentown Hosp
Allentown PA 18104
DICKSON JR, MD, Thomas B ORS
1730 Chew St
Allentown PA 18104
DILCHER, MD, Robert H U
515 N Main St
Allentown PA 18104
DIMICK, MD, Dean F IM
Allentown Hospital
Allentown PA 18102
DOLL JR, MD, Robert B IM
2533 Walnut St
Allentown PA 18104
DORSEY, MD, James T OBG
910 Turner St
Emmaus PA 18049
DOTTOR, MD, Albinka J HEM
601 Delaware Ave
Bethlehem PA 18015
DRY, MD, Frederick A GP
2347 Riverbend Road
Allentown PA 18103
DUBBS, MD, Alfred W CD
1443 Hamilton St
Allentown PA 18102
DUNN, MD, Jerome AI
401 N 17th Street Ste 204
Allentown PA 18104
EARNEST, MD, Tamar D GS
1251 S Cedar Crest 301-C
Allentown PA 18103
EDDINGER, MD, Leo C FP
951 N Fourth St
Allentown PA 18102
ENDRES, MD, Warren H GP
6000 Main St
Fogelsville PA 18051
ESLER JR, MD, James W AN
421 Chew Street 3-C
Allentown PA 18102
EVERETT, MD, Harold E IM
R D 4 Box 55
Northampton PA 18067
FALCONE, MD, Domenico AN
2335 Riverbend Road
Allentown PA 18103
FARRELL, MD, Peter E OTO
1251 S Cedar Crest Blvd
Allentown PA 18103
FEENEY, MD, Robert A FP
3710 Hamilton St
Allentown PA 18104
FELDMAN, MD, Larry B IM
1251 S Cedar Crest Blvd
Allentown PA 18103
FERRARA, MD, Frank M AN
5800 Ridge Avenue
Philadelphia PA 19128
FETTERMAN, MD, Henry H OBG
501 N 17th St
Allentown PA 18104
FETZER, MD, Arthur E U
1210 S Cedar Crest Blvd
Allentown PA 18103
FIEDLER, MD, Howard T P
2030 S Ocean Dr Apt 314
Hallandale FL 33009
FIELD-MUNVES, MD, Ellen M RHU
421 Chew Street
Allentowon PA 18102
FINCH, MD, Frank G IM
23Rd & Livingston Sts
Allentown PA 18104
FISTER, MD, Frederick D GP
R D 2 Box 556
Wescosville PA 18106
FITZGERALD, MD, James L OBG
811 N 19th St
Allentown PA 18104
FITZSIMONS, MD, Thomas R DR
1301 South 24th Street
Allentown PA 18103

FOOSKAS, MD, Stephen P IM
119 N 10th Street
Emmaus PA 18049
FOX, MD, Stewart TS
1210 S Cedar Crest Blvd
Allentown PA 18103
FOX, MD, William F OM
9 N Fourth St
Coplay PA 18037
FRAILEY JR, MD, William W GS
4137 Ravenswood Road
Allentown PA 18103
FRANKENFIELD, MD, Bruce A IM
2200 Hamilton St Rm 203
Allentown PA 18104
FRIEDBERG, MD, Milton J ON
2200 Hamilton St
Allentown PA 18104
FROMM, MD, Mitchel L TR
Allentown Hospital
Allentown PA 18102
FUGAZZOTTO, MD, Pasquale J PD
401 N 17th Street
Allentown PA 18104
GALGON, MD, John P PUD
1162 Bellair Dr
Allentown PA 18103
GARCIA, MD, Jose R IM
421 Chew St Ste 2-C
Allentown PA 18102
GAYLOR, MD, Donald H GS
3761 Devonshire Rd
Allentown PA 18103
GAYLOR, MD, Theodore H OTO
1251 S Cedar Crest Blvd
Allentown PA 18103
GEARHART, MD, Lyster M OBG
501 N 17th St
Allentown PA 18104
GEE, MD, William GS
1524 Linden Street
Allentown PA 18102
GELLER, MD, Edward I GP
803 Alabama Woods Lane
Orlando FL 32824
GELLER, MD, Michael H DR
1200 S Cedar Crest Blvd
Allentown PA 18105
GERCHMAN, MD, Leroy B US
3710 Hamilton St
Allentown PA 18104
GINSBERG, MD, Gene H IM
1210 S Cedar Crest Blvd
Allentown PA 18103
GITTLEMAN, MD, Mark A GS
121 N Cedar Crest Blvd
Allentown PA 18104
GLAZERMAN, MD, Larry R OBG
401 North 17th Street
Allentown PA 18104
GLUECK, MD, David G FP
3710 Hamilton St
Allentown PA 18104
GOLDFARB, MD, Daniel D P
121 N Cedar Crest Blvd
Allentown PA 18104
GOLDFARB, MD, Harold J OPH
2004 Allen St
Allentown PA 18104
GOLDSMITH, MD, Charles P OPH
Liberty Sq Med Ctr
Allentown PA 18104
GOOD, MD, Harry S GS
1711 Hamilton St
Allentown PA 18104
GOODREAU, MD, James J CDS
501 N 17th Street Ste 205
Allentown PA 18104
GORDON, MD, Charles A IM
1210 S Cedar Crest Blvd
Allentown PA 18103
GORDON, MD, Michael J OTO
1251 S Cedar Crest Blvd
Allentown PA 18103
GRASSI, MD, Joseph J PM
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Allentown PA 18103
GREYBUSH, MD, Joseph N OBG
401 North 17th Street
Allentown PA 18104
GROFF, MD, Gerald D RHU
1405 N Cedar Crest Blvd
Allentown PA 18104
GRUNBERG, MD, Robert W NEP
50 S 18th St
Easton PA 18042
GUZZO, MD, Joseph C NEP
2200 Hamilton St
Allentown PA 18104
HAFF, MD, Donald W GP
2871 Golf Circle
Emmaus PA 18049
HALLOCK, MD, Geoffrey PS
1210 S Cedar Crest Blvd
Allentown PA 18103
HAMADANI, MD, Houshang G P
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121 N Cedar Crest Blvd
Allentown PA 18104
HARVEY, MD, Kenneth L GP
302 Walnut St
Catasauqua PA 18032
HASTINGS JR, MD, Leo J US
324 N Sixth St
Allentown PA 18102
HEFFERNAN, MD, Andrew H PS
1621 N Cedar Crest Blvd
Allentown PA 18104
HEILIGMAN, MD, Nathan H GER
823 North 23rd
Allentown PA 18104
HENRIQUEZ, MD, Jack A EM
2280 Yorkshire Cir
Allentown PA 18103
HENTOSH, MD, John P PD
401 N 17th Street 205
Allentown PA 18104
HERTZ, MD, Charles S GS
Pocono Lake Pres PA 18348
HERTZ, MD, Jonathan IM
1210 S Cedar Crest Blvd
Allentown PA 18103
HILL, MD, E Merton PH
1833 W Congress St
Allentown PA 18104
HOFFMAN, MD, Arthur D IM
951 N Fourth Street
Allentown PA 18102
HOFFMAN, MD, William W GP
2416 Third St
Whitehall PA 18052
HOFFMANN, MD, Ursula M FP
P O Box 158
Center Valley PA 18034
HOLLAND, MD, Clarence A GS
421 Chew Street 3-B
Allentown PA 18102
HOLLAND JR, MD, Clarence A GS
421 Chew Street 3-B
Allentown PA 18102
HORVAT, MD, John F IM
401 N 17th Street #201
Allentown PA 18104
HOUIDES, MD, Athanasios C GS
219 N 17th St
Allentown PA 18104
HUDSON JR, MD, Howard E AN
1627 Chew St
Allentown PA 18102
HUTCHINSON, MD, Thomas A OBG
2908 Reading Rd
Allentown PA 18103
HYMAN, MD, Herbert L GE
401 N 17th Street
Allentown PA 18104
ILIOFF, MD, Gregory L FP
15Th & Elm Streets Apt 312
Allentown PA 18102
JAEGER, MD, Robert M NS
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Allentown PA 18103
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Allentown PA 18104
JAFFE, MD, John S U
1210 S Cedar Crest Blvd
Allentown PA 18103
JOHNSON, MD, Charles F GPM
2881 Golf Circle
Emmaus PA 18049
JOHNSON, MD, Douglas E NEP
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Allentown PA 18104
JONES, MD, David G OPH
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Allentown PA 18104
JONES, MD, Stuart A NM
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R D 1 Box 16-A
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Allentown PA 18104
KATZ, MD, Mitchell E FP
727 N 19th St
Allentown PA 18104
KAUFMAN, MD, Barre D RHU
1405 N Cedat Crest Blvd
Allentown PA 18104
KAUFMAN, MD, Jay H PUD
1210 S Cedar Crest Blvd
Allentown PA 18103

KEAN, MD, Dennis W PD
1551 Turner St
Allentown PA 18102
KEBLISH JR, MD, Peter A ORS
1730 Chew St
Allentown PA 18104
KELLEY JR, MD, Charles F PD
1251 S Cedar Crest Blvd
Allentown PA 18103
KENVIN, MD, John E PD
811 N 19th
Allentown PA 18104
KHAN, MD, Abdul A CDS
1275 S Cedar Crest Blvd
Allentown PA 18103
KHINDRI, MD, Chetan D CDS
1040 S Cedar Crest Blvd
Allentown PA 18103
KHOSHBIN, MD, Bijan PTH
1608 33Rd Street Sw
Allentown PA 18103
KHUBCHANDANI, MD, Indru T CRS
1275 S Cedar Crest Blvd
Allentown PA 18103
KIBELSTIS, MD, John A PUD
1210 S Cedar Crest Blvd
Allentown PA 18103
KIESEL, MD, Robert OPH
1503 N Cedar Crest Blvd #123
Allentown PA 18104
KIM, MD, Chung H NM
3081 Elm Dr
Allentown PA 18103
KIM, MD, Jin I AN
1158 Treeline Drive
Allentown PA 18103
KIM, MD, Kyu S PM
1736 Hamilton Street
Allentown PA 18104
KINTZEL, MD, James E NEP
2200 Hamilton St
Allentown PA 18104
KISTLER, MD, Kermit K OPH
106 N 13th St
Allentown PA 18102
KLASKO, MD, Stephen K OBG
401 North 17th Street
Allentown PA 18104
KLECKNER, MD, Francis S GE
1275 S Cedar Crest Blvd
Allentown PA 18103
KLEES, MD, Athanasius CLP
1679 Lehigh Pkwy North
Allentown PA 18103
KLOIN, MD, Jay E IM
4441 Dogwood Circle
Emmaus PA 18049
KLOTZ, MD, Donald J FP
36 S 17th St
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KNAPPER, MD, Elizabeth J D
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KOHAN, DO, David A AN
421 Chew St Ste C-3
Allentown PA 18102
KOPENHAVER, MD, Donald B OBG
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KOPYT, DO, Nelson P IM
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KOVACS, MD, Robert J IM
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Allentown PA 18103
KRATZER, MD, Guy L CRS
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Allentown PA 18104
KRISCH, MD, Ronald A P
3281 W Washington St
Allentown PA 18104
KUCHARCZUK, MD, John B OBG
1357 Main St
Northampton PA 18067
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Allentown PA 18104
LAM, MD, Carl A OBG
160 Main St
Emmaus PA 18049
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401 N 17th Street #303
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LAUFER, MD, Fred FP
1344 Hamilton St
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Augusta GA 30909
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2949 Allen St
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1015 N 32nd St
Allentown PA 18104
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Allentown PA 18102
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CHUNG, MD, Hi-Young OBG
1010 E Mountain Dr
Wilkes Barre PA 18702
CIOTOLA, MD, Augustine A FP
565 N Laurel St
Hazleton PA 18201
CIOTOLA, MD, Thomas J CD
1730 E Broad St
Hazleton PA 18201
COHEN, MD, Tom FP
287A1 Mountainview Dr
Dallas PA 18612
CONAHAN, MD, Thomas J R
336 W Green St
Hazleton PA 18201
CONSALVO, MD, John A EM
182 S Franklin St
Wilkes-Barre PA 18701
COONEY, MD, Edward A FP
540 Pierce Street
Kingston PA 18704
COOPER, MD, David R ORS
695 Kidder St
Wilkes Barre PA 18702
COOPER, MD, Helen C IM
42 E Main St
Plymouth PA 18651
COOPER, MD, Joseph E GP
380 Old River Rd
Wilkes Barre PA 18702
CORAZZA, MD, Leo J IM
2 E Broad St
Hazleton PA 18201
CORDERO, MD, Hermelinda R
Wilkes-Barre Gen Hosp
Wilkes-Barre PA 18764
COREY, MD, Peter J GS
35 W Linden St Ste A220
Wilkes Barre PA 18702
CORRIGAN, MD, Lawrence F PD
29 W Holly St
Hazleton PA 18201
COYLE, MD, John J OPH
2 E Broad St
Hazleton PA 18201
CRAMTON, MD, David C IM
610 Wyoming Ave
Kingston PA 18704
CROMPTON, MD, Richard E FP
206 Carverton Rd
Trucksville PA 18708
CZWALINA, DO, Robert FP
32 W Fourth St
Wyoming PA 18644
DAINIUS, MD, Alfonsas PH
28 Hillcrest Dr
Dallas PA 18612
DANCA, MD, Alfred F ORS
35 W Linden St
Wilkes Barre PA 18702
DANISHANKO, MD, Albert G GP
174 Scott St
Wilkes Barre PA 18702
DAVIS, MD, Daniel T ORS
R D 5 Sutton Rd
Shavertown PA 18708
DAVIS, MD, George B GP
256 N Maple Ave
Kingston PA 18704
DAW, MD, William J U
4111 N 25th Ave
St Petersburg FL 33713
DEBONIS, MD, Charles S IM
972 Wyoming Ave
Forty Fort PA 18704
DECKER, MD, Peter G IM
149 Dana St
Wilkesbarre PA 18702
DECURTIS, MD, George M FP
534 Wyoming Ave
Kingston PA 18704
DEDHIA, MD, Champak R
70 Pinewood Dr
Laflin PA 18702
DEGENNARO, MD, Patrick J R
Wilkes Barre Gen Hosp
Wilkes Barre PA 18764
DEJOSEPH, MD, Robert L CD
1730 E Broad St
Hazleton PA 18201
DELLA-ROSA JR, MD, John J N
1010 E Mountain Drive
Wilkes Barre PA 18702
DESSEN, MD, Edgar L DR
Northeastern Bank Bldg
Hazleton PA 18201
DEVLIN, MD, Michael F AN
1010 E Mountain Drive
Wilkes Barre PA 18702
DIGIOVANNI, MD, Vincent J N
296 S River Street
Wilkes Barre PA 18702
DIORIO, MD, James P IM
1217 Wyoming Ave
Forty Fort PA 18704
DIORIO, MD, Norina M FP
998 Wyoming Ave
Forty Fort PA 18704
DITTMAN, MD, Thomas H PUD
2 E Broad St
Hazleton PA 18201
DOLPHIN, MD, Murray OPH
400 Third Avenue
Kingston PA 18704
DORMANS, MD, Adrian A FP
205 Indian Creek Drive
Wilkes Barre PA 18702
DOSTAL, MD, Julie A FP
R D 4 Box 244
Dallas PA 18612
DRAPIEWSKI, MD, John F PTH
40 Tilbury Terrace
West Nanticoke PA 18634
DRAPIEWSKI, MD, Vincent A IM
Eight Church St
Wilkes Barre PA 18702
EARLES, MD, Gordon H FP
25 W Ross St
Wilkes Barre PA 18702
EISENHARDT, DO, Bruce T GP
1465 Dartmouth Dr
Bethlehem PA 18017
ENGLISH, MD, Richard B FP
Narrows Office Bldg
Kingston PA 18704
FARRELL, MD, Dorothy A N
480 Pierce St
Kingston PA 18704
FASCIANA, MD, Guy M IM
243 South Main Street
Pittston PA 18640
FATEMI, MD, Jalal B TS
35 W Linden St Ste B220
Wilkes Barre PA 18702
FEERICK, MD, John P N
Geisinger Med Grp
Wilkes Barre PA 18702
FEINSTEIN, MD, Peter A ORS
35 W Linden St
Wilkes Barre PA 18702
FELLERMAN, MD, Herbert IM
35 W Linden St
Wilkes Barre PA 18702
FERRARO, MD, Michael M OBG
425 Tioga Ave
Kingston PA 18704
FESCINA, MD, Joseph V GYN
217 N Laurel St
Hazleton PA 18201
FOLDES, MD, Julius PTH
105 W Broad St
Hazleton PA 18201
FOURNIER, MD, Raymond OBG
27 Third Avenue
Union City PA 16438
FRANCIS, MD, Leon R FP
P O Box 556
Bloomsburg PA 17815
FREEDMAN, MD, Louis J OBG
534 Wyoming Ave
Kingston PA 18704
FREIFELD, MD, Martin L OBG
480 Pierce Street
Kingston PA 18704
FRIED, MD, Martin B GE
Courthouse Square Towers
Wilkes Barre PA 18704
FRIEDMAN, MD, Henry B GE
610 Wyoming Ave
Kingston PA 18704
FRYE, MD, John W OBG
8 Cedar Dr Birchwood Hills
Plains PA 18705
FURNER, DO, Carl L US
125 Johns Ave
Hazleton PA 18201
GAIA, MD, Juan D DR
451 Third Ave
Kingston PA 18704
GALLAGHER, MD, Henry G GP
35 Lake St
Dallas PA 18612
GAZEK, MD, Francisco A CD
2 E Broad St
Hazleton PA 18201
GAZOWSKI, MD, Thomas E US
82 Division St
Kingston PA 18704
GIBBONS, MD, Robert J GS
629 W Diamond Ave
Hazleton PA 18201
GIERING, MD, John F IM
272 Pierce St
Kingston PA 18704
GILL, MD, John J R
451 Third Ave
Kingston PA 18704
GIORDANO, MD, Nicholas D IM
200 Second Ave
Kingston PA 18704
GORSKI, MD, Eugene D FP
Family Health Ctr
Dallas PA 18612
GRABOWSKI, MD, Marie A PD
259 E Union St
Nanticoke PA 18634
GRECO, MD, Victor F TS
Greco Med Arts Bldg
Drums PA 18222
GREENBERG, MD, Andrew A AN
144 Lathrop Court
Kingston PA 18704
GREENWALD, MD, David W ON
35 W Linden St
Wilkes Barre PA 18702
GREER, MD, Benjamin J PM
The John Heinz Inst Of Rehab
Wilkes Barre PA 18703
GRIESMER, MD, Paul D OBG
425 Tioga Ave
Kingston PA 18704
GROSSMAN, MD, Ira C U
470 Wyoming Ave
Kingston PA 18704
GUNDERSON, MD, Robert L ORS
1710 E Broad St
Hazleton PA 18201
GUNSTER, MD, Gerald D OBG
R D 1 Upper Demunds Rd
Dallas PA 18612
GUTTERMAN, MD, Paul NS
1740 E Broad St
Hazleton PA 18201
HABER, MD, Arthur S R
214-19 Northeastern Bldg
Hazleton PA 18201
HAKKARINEN, MD, William D FP
540 Pierce Street
Kingston PA 18704
HANLON, MD, Paul A OBG
543 Westmoreland Avenue
Kingston PA 18704
HARBOUR, MD, Robert C OPH
601-605 Wyoming Ave
Kingston PA 18704
HARRIS, MD, Harold J GP
228 S Franklin St
Wilkes-Barre PA 18702
HARRIS, MD, Howard Y PD
40 James St
Kingston PA 18704
HARRIS, MD, Ronald I END
1010 E Mountain Dr
Wilkes Barre PA 18702
HAZLETT, MD, Jane OBG
480 Pierce St Rm 319
Kingston PA 18704
HAZLETT, MD, William H OBG
534 Wyoming Ave
Kingston PA 18704
HERNANDEZ, MD, Wilbert E AN
1172 Scott St
Wilkes Barre PA 18705
HERRMANN, MD, William J OBG
1010 E Mountain Dr
Wilkes Barre PA 18702
HEYDT, MD, Stuart OS
1010 E Mountain Dr
Wilkes Barre PA 18702
HILLERMAN, MD, Braxton L OTO
Geisinger Med Grp
Wilkes Barre PA 18702
HLAVAC, MD, Cheryl A FP
65 Laurel Dr
Scranton PA 18505
HOLLERAN, MD, Bernard L IM
308 W Eighth St
West Wyoming PA 18644
HORVAT, MD, Arthur J GP
449 Stephenson St
Duryea PA 18642
HOWANITZ, MD, Emil P GS
619 United Penn Bank Bldg
Wilkes Barre PA 18701
HUDOCK JR, MD, George E PTH
51 E Valley View Dr
Courtdale PA 18704
HUGHES, MD, Paul J FP
540 Pierce Street
Kingston PA 18704
HUSAIN, MD, Zahid RHU
35 W Linden St
Wilkes Barre PA 18702
IMBRIGLIA, MD, Joseph E HS
155 W River St
Wilkes Barre PA 18702
IMPERIALE, MD, Salvatore M R
Country Club Rd Box 410 A
Dallas PA 18612
JACOBS, MD, Irvin PD
One Sterling Ave
Dallas PA 18612
JAMES, MD, Russell E IM
52 W Hoyt St
Kingston PA 18704
JANERICH, MD, Albert D PM
Geisinger Med Grp
Wilkes Barre PA 18702
JANG, MD, Jang-Huei OTO
225-226 Northeastern Bldg
Hazleton PA 18201
JANJIGIAN, MD, Edward R N
22 Pierce St
Kingston PA 18704
JOHNSON, MD, Dorothy E GP
25 W Ross St
Wilkes Barre PA 18702
JONES, MD, Robert T US
508 Foxwood Lane
Paoli PA 19301
JOSEPH, MD, Raymond J GP
165 Carey Ave
Wilkes Barre PA 18702
JULIUS, MD, Ernest L FP
245 E South St
Wilkes Barre PA 18702
KAFRISSEN, MD, Steven R P
35 Yeager Ave
Forty Fort PA 18704
KAMEEN, MD, Anthony J OPH
601-605 Wyoming Ave
Kingston PA 18704
KANTOR, MD, Milton IM
245 E South St
Wilkes Barre PA 18702
KAO, MD, Yu S N
9 Farmhouse Rd
Mountain Top PA 18707
KATLIC, MD, Mark R TS
35 W Linden St
Wilkes Barre PA 18702
KELLMAN, MD, Ian A DR
R D 5 625 Hampton Road
Shavertown PA 18708
KENNEDY, MD, John N IM
R D 5
Shavertown PA 18708
KERR, MD, Robert M IM
204 S Franklin St
Wilkes Barre PA 18701
KERSTEEN EXEC, DIR, Duane E US
130 S Franklin St
Wilkes Barre PA 18701
KETTRICK, MD, James P ABS
2 E Broad St
Hazleton PA 18201
KIM, MD, Hyung-Bae OBG
1010 E Mountain Dr
Wilkes Barre PA 18702
KISTLER, MD, Charles J OTO
Lake Silkeworth
Hunlock Creek PA 18621
KISTLER, MD, David W FP
245 E South St
Wilkes Barre PA 18702
KLEIN, MD, Joseph M PD
2089 Gulf Of Mexico Dr
Longboat FL 33548
KLEM, MD, Albert J GP
194 Dorrance St
Kingston PA 18704
KOEHL JR, MD, C Warren PTH
Elmcrest Dr
Dallas PA 18612
KOENIG, MD, Johann A PTH
646 N Church St
Hazleton PA 18201
KONECKE, MD, M Louis OS
33 Forest Rd
Mountaintop PA 18707
KONECKE, MD, Ron J R
Lake Road
Bear Creek PA 18602
KOO, MD, Wook H AN
Mountainview Dr
Dallas PA 18612
KOPEN, MD, Dan F GS
480 Pierce St
Kingston PA 18704
KOTCH, MD, Michael J GP
40 N Market St
Nanticoke PA 18634
KOWALSKI, MD, Joseph J P
676 Wyoming Avenue
Kingston PA 18704
KOZLEK, MD, Thomas F OTO
534 Wyoming Ave
Kingston PA 18704
KRIVENKO, MD, Charles A FP
Sterling & Machell Aves
Dallas PA 18612
KRYWICKI, MD, William J ORS
Geisinger Med Group
Wilkes Barre PA 18702
KULBASKI, MD, Frank E R
25 Mary St
Ashley PA 18706
KURELLO, MD, Phillip J FP
540 Pierce Street
Kingston PA 18704
LABBATE, MD, Victor A RHU
35 W Linden St
Wilkes Barre PA 18702
LABUZ, MD, Eugene F GP
741 W Diamond Ave
Hazleton PA 18201
LAKATOS, MD, Nicholas R GS
143 E Broad St
Nanticoke PA 18634
LANDAU, MD, Leo W PD
534 Wyoming Ave
Kingston PA 18704
LAZAR, MD, Richard J FP
605 Main St
Duryea PA 18642
LEASE, MD, John R ORS
1710 E Broad St
Hazleton PA 18201
LEE, MD, Ki B OBG
1730 E Broad St
Hazleton PA 18201
LEHMAN, MD, Clinton J IM
39 Westminster Dr
Dallas PA 18612
LENAHAN, MD, Paul J GP
159 Lakeview Dr Penn Lake
Whitehaven PA 18661
LENTINI, MD, J Charles FP
158 S Sherman Street
Plains PA 18705
LENTINI, MD, Joseph A GP
270 S River Street
Plains PA 18705
LENYO, MD, George E FP
R D 2 Hometown
Tamaqua PA 18252
LOBITZ, MD, Stanley A FP
540 Pierce Street
Kingston PA 18704
LOFTUS, MD, Joseph A GP
10 Union St
Wilkes Barre PA 18705
LOMBARD, MD, Michael F FP
Box 55
Bear Creek PA 18602
LONG, MD, Julian S IM
26 Miner St
Wilkes Barre PA 18702

LONG, MD, Paul R D
1010 E Mountain Dr
Wilkes Barre PA 18702
LOTTICK, MD, Edward A FP
789 Wyoming Ave
Kingston PA 18704
LOVRINIC, MD, Daniel F ORS
1710 E Broad St
Hazleton PA 18201
LUCAS, MD, Irene D FP
7026 Horizon Village
Mountaintop PA 18707
LUCCHINO, MD, David B GS
R D 5 Box 312
Shavertown PA 18708
LUNG, MD, Richard J PS
10 W Chestnut Street Ste 12
Hazleton PA 18201
MACKALL, MD, Samuel J NS
480 Pierce St
Kingston PA 18704
MAGUIRE-LITCHMAN, MD, FP
Maureen R
540 Pierce Street
Kingston PA 18704
MANCIA, MD, Bonita M OBG
676 Wyoming Ave
Kingston PA 18704
MANGANIELLO, MD, Charles M FP
1099 S Township Blvd
Pittston PA 18640
MANRIQUE, MD, Jose V CD
Eight Church St
Wilkes Barre PA 18702
MARTYAK, MD, Nicholas A PD
1740 E Broad St
Hazleton PA 18201
MATSKO, MD, Michael E GP
R D 1 Box 362-J
Tamaqua PA 18252
MCALOOSE, MD, Louis T U
Hersheys Mill
West Chester PA 19380
MCGILL, MD, Kenneth W FP
1004 Wyoming Avenue
Forty Fort PA 18704
MCGRANE, MD, Maria K TS
Route 118 Box 700
Dallas PA 18612
MCGRATH, MD, Edmund W GP
Box 83
Lehman PA 18627
MENIO, MD, John N FP
32 W Main St
Plymouth PA 18651
MESAROS, MD, Michael J EM
N P W Med Ctr E R Dept
Wilkes Barre PA 18711
MICHELSTEIN, MD, Richard D GE
221 Joseph Dr
Kingston PA 18704
MITCHELL, MD, Arthur B FP
540 Pierce Street
Kingston PA 18704
MOKYCHIC, MD, Walter E GP
42 N Pioneer Ave
Shavertown PA 18708
MONTAGUE, MD, Elisabeth EM
604 Meadows Newberry Estates
Dallas PA 18612
MONTGOMERY, MD, Charles C OS
924 S Franklin St
Wilkes Barre PA 18702
MOORE, MD, David H GE
R D 2 Box 238
Dallas PA 18612
MOORE, MD, David K FP
540 Pierce Street
Kingston PA 18704
MORGART, MD, Douglas R EM
7 Old North Rd
Mountaintop PA 18707
MORRISON SR, MD, Joseph F OPH
130 Forest Rd
Mountaintop PA 18707
MOSES, MD, George P GS
Eight Church St
Wilkes Barre PA 18702
MUKERJEE, MD, Manju G U
40 N Market St
Nanticoke PA 18634
MUMIE, MD, Lawrence E FP
34 Holiday Drive Apt 181
Kingston PA 18704
MYERS, MD, Charles E IM
610 Wyoming Ave
Kingston PA 18704
MYERS, MD, Frederick B IM
610 Wyoming Ave
Kingston PA 18704
NAUSS, MD, Thomas J PS
R D 3
Moscow PA 18444
NIEZGODA, MD, Paul E GE
21 Tamanini Rd
Wyoming PA 18644
NORK, MD, Edward P OPH
777 Wyoming Ave
Kingston PA 18704
NOVINGER, MD, Quentin T PD
1010 E Mountain Dr
Wilkes Barre PA 18702

ODONNELL, MD, George J PD
272 S River St
Wilkes Barre PA 18702
OH, MD, Yong W PTH
106 Dina Ave
Hazleton PA 18201
OLSHEMSKI, MD, Frank C FP
21 Woodcrest Drive
Wilkes Barre PA 18702
OLSON, MD, Ronald A OPH
341 Wyoming Ave
West Pittston PA 18643
ORLANDO, MD, Joseph D DR
1099 S Township Blvd
Pittston PA 18640
OUANO, MD, Romeo C DR
425 W Diamond Avenue
Hazleton PA 18201
OWENS, MD, David E FP
245 E South St
Wilkes Barre PA 18702
PACURARIU, MD, Radu I OPH
82 S Washington St
Wilkes Barre PA 18701
PADEN, MD, Drue R FP
245 E South St
Wilkes Barre PA 18702
PANZER, MD, Glenn M FP
534 Bennett St
Luzerne PA 18709
PATEL, MD, Satish D DR
Wilkes Barre Gen Hosp
Wilkes Barre PA 18764
PEGUERO, MD, O Alberto GS
1730 E Broad St
Hazleton PA 18201
PELCZAR, MD, Eugene W GP
71 Tilbury Terrace
West Nanticoke PA 18634
PENUGONDA, MD, Dwaraki B PD
Eight Church St
Wilkes Barre PA 18702
PENUGONDA, MD, Haragopal S U
35 W Linden St
Wilkes Barre PA 18702
PERIYANAYAGAM, MD, NS
Srinivasan
1740 E Broad St
Hazleton PA 18201
PERKINS, MD, Charles G FP
260 Toftrees Ave Apt 317
State College PA 16801
PETERS, MD, Frank S IM
173 E Broad St
Nanticoke PA 18634
PETERS JR, MD, Robert H GP
974 Kasko Road
Shavertown PA 18708
PILAREK, MD, Valentine F GP
40 N Market St
Nanticoke PA 18634
PISZCZEK, MD, Joseph E IM
70 E Main St
Plymouth PA 18651
POLIDORA, MD, Frank C ORS
1730 E Broad St
Hazleton PA 18201
POSATKO, MD, Peter C GP
52 Hudson Rd
Plains PA 18705
POTERA, MD, Leo P IM
303 James St
Kingston PA 18704
POTORSKI, MD, Robert D J IM
36 E Oak St
Pittston PA 18640
PRASAD, MD, Shishir C GS
1099 S Township Blvd
Pittston PA 18640
PRESPER, MD, John H NS
1010 E Mountain Drive
Wilkes Barre PA 18702
PUGLIESE, MD, Joseph F OPH
601-605 Wyoming Ave
Kingston PA 18704
PUMA, MD, Samuel J GS
44 W Bennett St
Kingston PA 18704
PUTPRUSH, MD, Joseph R PTH
1000 E Mountain Dr
Wilkes Barre PA 18711
PYUN, MD, Kwang W GP
401-403 First Valley Bank
Hazleton PA 18201
QUERCI, DO, John C IM
1825 Wyoming Ave
Exeter PA 18643
RACHO, MD, George J OTO
22 N Church St
Hazleton PA 18201
RAKLEWICZ, MD, Michael C ORS
Courthouse Sq Towers
Wilkes Barre PA 18702
RAVICHANDRAN, MD, Chitra R IM
P O Box 661
Conyngham PA 18219
REICH, MD, Harry GYN
480 Pierce St
Kingston PA 18704
REICH, MD, Sylvia R GP
171 Wyoming Ave
Wyoming PA 18644

RICK JR, MD, William J P
777 Wyoming Ave
Kingston PA 18704
RIMPLE, MD, David F CD
610 Wyoming Ave
Kingston PA 18704
RIOFSKI, MD, Anthony F A
1340 N Washington St
Wilkes Barre PA 18705
RIZZO, MD, Samuel V OTO
554 Monument Avenue
Wyoming PA 18644
ROBINS, MD, Isadore M GP
109 S Franklin St
Wilkes Barre PA 18701
ROBINSON, MD, Joseph PD
47 Pierce St
Kingston PA 18704
RODA, MD, Paul I HEM
1740 E Broad Street
Hazleton PA 18201
ROJAS, MD, Julio R OPH
1720 E Broad Street
Hazleton PA 18201
ROSCKOWFF, MD, Carol M PD
534 Wyoming Ave
Kingston PA 18704
ROSENBERG, MD, Irvin E IM
1415 Ocean Shore Blvd
Ormond Beach FL 32074
ROSENSWEIG, MD, William D
33 Holiday Dr
Kingston PA 18704
ROTHSCHILD, MD, John A NEP
56-58 W Linden St
Wilkes Barre PA 18702
RUBIN, MD, Richard B P
R D 10 Clear Brook
Wilkes Barre PA 18702
RUDUSKY, MD, Basil M CD
15 Public Sq
Wilkes Barre PA 18701
RUGGIERO, MD, Nicholas J CD
225 South River Street
Plains PA 18705
RUMBAUGH, MD, Marshall U U
R D 1 Box 507
Dallas PA 18612
SAHILLIOGLU, MD, Refik PUD
Mercy Hosp
Wilkes Barre PA 18765
SAIDMAN, MD, Lester M FP
Wilkes Barre Gen Hosp
Wilkes Barre PA 18764
SALAZAR, MD, Pedro A U
54 N Locust St
Hazleton PA 18201
SAMII, MD, Abdol H N
10 W Dorrance St
Kingston PA 18704
SANDS, MD, Jeffrey J NEP
56-58 W Linden St
Wilkes Barre PA 18702
SANDS, MD, S David PD
676 Wyoming Avenue
Kingston PA 18704
SARAS, MD, Peter L IM
101 S Laurel St
Hazleton PA 18201
SAVAGE, MD, Donald J OPH
601-605 Wyoming Ave
Kingston PA 18704
SAVAGE, MD, Peter J GP
28 Center Ave
Plymouth PA 18651
SCARANO, MD, Domenico TS
1010 E Mountain Dr
Wilkes Barre PA 18702
SCHADE, MD, John F GS
609 Hazleton Natl Bank
Hazleton PA 18201
SCHEERS, MD, George F OBG
101 W Broad Street
Hazleton PA 18201
SCHIOWITZ, MD, Albert GS
35 W Linden St
Wilkes Barre PA 18702
SCHIOWITZ, MD, Mark F GS
35 W Linden St
Wilkes-Barre PA 18702
SCHLESINGER, MD, Sam GP
218 W Tenth St
Hazleton PA 18201
SCHMIDT, MD, Arnold P PTH
55 Spruce St
Mountaintop PA 18707
SCHOOLEY, MD, Frank B IM
150 Lake St
Dallas PA 18612
SCHREINER, MD, Glenwood R GP
30 W Broad St
West Hazleton PA 18201
SCHULMAN, MD, Norman TR
Wilkes Barre Gen Hosp
Wilkes Barre PA 18764
SCHWITER, MD, E Joseph CD
1010 E Mountain Dr
Wilkes Barre PA 18702
SCOTT, MD, Alvin J GP
69 W Union St
Shickshinny PA 18655

SCOTT, MD, Durelle T IM
610 Wyoming Ave
Kingston PA 18704
SCROBOLA, MD, Charles C GPM
638 Wyoming Ave
Wyoming PA 18644
SEROSKA, MD, Phillip J EM
119 Forest Rd
Mountain Top PA 18707
SGARLAT, MD, Joseph R ORS
109 James St
Kingston PA 18704
SHAFER, MD, Edward A FP
219 N Sprague Ave
Kingston PA 18704
SHARKEY, MD, Thomas G OPH
601-605 Wyoming Ave
Kingston PA 18704
SHERWOOD, MD, John W FP
55 New Alexander St
Wilkes Barre PA 18702
SHROFF, MD, Farook K CD
Med Arts Bldg
Wilkes Barre PA 18702
SIBERSKI, MD, John R IM
327 N Main St
Plymouth PA 18651
SKINNER, MD, Bruce S IM
Hazleton Shopping Center
Hazleton PA 18201
SLUHOCKI, DO, Mark FP
5116 Old Zuck Road
Erie PA 16506
SMITH, MD, Donald C GS
130 Reef Rd
South Daytona FL 32019
SMITH, MD, Gary M FP
Rural Hlth Ctr
Noxen PA 18636
SMITH, MD, Henry F FP
126 S Mountain Blvd
Mountain Top PA 18707
SMITH JR, MD, Harry A ORS
259 S Franklin St
Wilkes Barre PA 18701
SOLOMON, MD, Cynthia A IM
679 Carey Avenue
Wilkes Barre PA 18702
SOMMA, MD, Richard M N
1010 E Mountain Dr
Wilkes Barre PA 18702
SPAGNOLETTI, MD, Louis IM
127 Old Short Hills Rd
West Orange NJ 07052
SPECTOR, DO, Howard L R
16 Longmeadow Lane
Mountaintop PA 18707
STANISH, MD, Stanley M FP
540 Pierce Street
Kingston PA 18704
STEGURA, MD, Barney A OPH
630 S Hanover St
Nanticoke PA 18634
STERNLIEB, MD, Sanford B US
35 W Linden St
Wilkes Barre PA 18702
STEWART, MD, Russell R AN
1010 E Mountain Drive
Wilkes Barre PA 18702
STISH JR, MD, Anthony G GP
600 Penn Ln
Hazleton PA 18201
STREET, MD, Thomas F GS
Center Plaza Ste 10
Hazleton PA 18201
STRICKER, MD, Robert S OS
375 Carey Ave
Wilkes Barre PA 18702
STUCCIO, MD, Dominick A U
Seven Concord Dr
Wilkes Barre PA 18702
STUCCIO, MD, Joseph J U
21 Fordham Rd Laflin
Wilkes Barre PA 18702
TAGGART, MD, George W OPH
2 E Broad St
Hazleton PA 18201
TEITELBAUM, MD, Carl OS
13 Summit View Dr
Mountaintop PA 18707
TESTA, MD, John W GP
108 Susquehanna Ave
West Pittston PA 18643
TOMEDI, MD, John R FP
16 Savoy Dr
Dallas PA 18612
TONREY, MD, Francis G FP
3421 Spanish Trail
Delray Beach FL 33444
UDOSHI, MD, Geeta M IM
Three Fox Hollow Dr
Dallas PA 18612
UDOSHI, MD, Mallapa B IM
Eight Church St
Wilkes Barre PA 18702
UMALI, MD, Idona C AN
1405 E Broad St
Hazleton PA 18201
USHINSKI, MD, Stanley C PDA
480 Pierce St Ste 209
Kingston PA 18704

VALENTI, MD, John T GP
54 Carey Ave
Wilkes Barre PA 18702
VENIT, MD, Bethany A PD
410 First Valley Bank Bldg
Hazleton PA 18201
VILLACRUSIS, MD, Oscar C P
23 Pine Tree Rd
Mountaintop PA 18707
VOLPETTI, MD, George W GS
34 W Linden St 220-A
Wilkes Barre PA 18702
VOUTSINAS, MD, Louisa V OBG
777 E Broad St
Hazleton PA 18201
WALSH, MD, James C D
30 Fordham Rd
Wilkes Barre PA 18702
WARTELLA JR, MD, Stephen R
Wilkes Barre Gen Hosp
Wilkes Barre PA 18764
WASNICK, MD, William GP
22 Lee Park Ave
Wilkes Barre PA 18702
WEISBAUM, MD, Simcheon D DR
1010 E Mountain Dr
Wilkes Barre PA 18702
WEISS, MD, William IM
270 S River Street
Plains PA 18705
WENNER, MD, Robert B FP
29 Calbeth Pl
Hazleton PA 18201
WICKS, MD, William A AN
3652 Inverness Dr
Sarasota FL 34243
WIESENFELD, MD, Nathaniel H DR
1010 E Mountain Dr
Wilkes Barre PA 18702
WILLET, MD, Andrew Allen FP
540 Pierce Street
Kingston PA 18704
WISE, MD, Richard J GP
103 Main St
Conyngham PA 18219
WITT, MD, Paul J FP
45 Mack St
Plains PA 18705
WOLANIN, MD, Janusz FP
40 N Market Street
Nanticoke PA 18634
WOOD, MD, Marlene B FP
540 Pierce Street
Kingston PA 18704
YAMULLA, MD, Stanley J GS
908 Northeastern Bank Bldg
Hazleton PA 18201
YANOSHAK, DO, Robert N FP
Village And Walk #300
Exton PA 19341
ZALATIMO, MD, Akram A OBG
534 Wyoming Ave
Kingston PA 18704
ZEVENEY JR, MD, Dennis J GS
75 Spruce St
Mountain Top PA 18707

LYCOMING

ABDEL-MESSEIH, MD, Adel A ON
904 W Fourth St
Williamsport PA 17701
AHMED, MD, Galal M PTH
Divine Providence Hosp
Williamsport PA 17701
AMSLER JR, MD, Fred R ORS
1711 Pentridge Cove
Williamsport PA 17701
ANDO, MD, Teodoro A AN
1352 Adele Road
Montoursville PA 17754
ANGLE, MD, William D OPH
1822 Homewood Ave
Williamsport PA 17701
BALLENTINE, MD, George N OBG
R D 3
Muncy PA 17756
BASTIAN, MD, James R OPH
1001 Grampian Blvd
Williamsport PA 17701
BECKLEY, MD, Robert F R
535 Guardlock Dr
Lock Haven PA 17745
BEDNARZ, MD, Wallace W R
1527 Harding Ave
Williamsport PA 17701
BELLES, MD, Terry A FP
145 Shaffer St
Williamsport PA 17701
BELTZ, MD, William R GS
1205 Grampian Blvd
Williamsport PA 17701
BERGER, MD, Gary W FP
Main St
Hughesville PA 17737
BIDDLE, MD, John E GP
212 Main St
Watsontown PA 17777
BINDER, MD, Mitchell J HEM
1100 Grampian Blvd
Williamsport PA 17701

BLOM, MD, Bohen M F PTH
Rd 3 Maddon Heights
Montoursville PA 17754
BLOM, MD, Johannes ND
1100 Grampian Blvd
Williamsport PA 17701
BLUMBERG, MD, Alexander W PD
923 Campbell St
Williamsport PA 17701
BOBEK, MD, Francis B FP
Six Pearle St
Elysburg PA 17824
BONNER, MD, Robert A OPH
2200 Grampian Blvd
Williamsport PA 17701
BONTOMASE, MD, Jasper E GP
24 Spruce Circle South
Barnegat NJ 08005
BOZIC, MD, Albert F OPH
57 E Fourth St
Williamsport PA 17701
BRICKHOUSE, MD, Herman M P
414 W Fourth St
Williamsport PA 17701
BRINK, MD, William R IM
410 Locust St
Williamsport PA 17701
BUMAGIN, MD, Michael S PS
P O Box 336
Williamsport PA 17703
BURKS, MD, John M CD
777 Rural Ave
Williamsport PA 17701
BUTKIEWICZ, MD, Bernard L DR
1505 Ritchey Street
Williamsport PA 17701
BUZZERD, MD, Harry W OTO
760 Glenwood Ave
Williamsport PA 17701
BYLER, MD, Philip R FP
1205 Grampian Blvd
Williamsport PA 17701
CALCE, MD, John V NM
1100 Grampian Blvd
Williamsport PA 17701
CALDER JR, MD, Joseph R IM
777 Rural Ave
Williamsport PA 17701
CALLENBERGER, MD, EM
George J
52 S Main St
Hughesville PA 17737
CAMPANA, MD, Joseph F OTO
151 E Third St
Williamsport PA 17701
CAMPANA, MD, Louis F GYN
107 Sixth St
Williamsport PA 17701
CICCARELLI, MD, Lee M IM
350 William St
Williamsport PA 17701
CIPOLLA, MD, Charles F GS
201 E Third St
Williamsport PA 17701
COFFMAN, MD, Kaohlin M EM
R D 4 Box 634
Montoursville PA 17754
COHEN, MD, Edwin E GS
1001 Grampian Blvd
Williamsport PA 17701
COLE, MD, Charles E P
699 Rural Ave
Williamsport PA 17701
COLLINS, MD, Leonard R OBG
528 W Fourth St
Williamsport PA 17701
CONWAY, MD, Cyril F OBG
1300 Woodmont Ave
Williamsport PA 17701
COOPER, MD, Kenneth L OBG
230 Dunbar Rd
Williamsport PA 17701
COZINE, MD, Richard A OPH
1420 Campbell St
Williamsport PA 17701
DOUGLAS, MD, Donald D GE
1205 Grampian Blvd
Williamsport PA 17701
DUNKLE, MD, Neil F A
201 N Broad
Jersey Shore PA 17740
DURRWACHTER, MD, Robert J GP
R D 2
Montoursville PA 17754
ECKER JR, MD, Herbert A PS
420 W Fourth St
Williamsport PA 17701
ECKER SR, MD, Herbert A PS
420 W Fourth St
Williamsport PA 17701
EISTER, MD, Ronald N FP
1001 First Avenue
Williamsport PA 17701
ENGLISH, MD, Joseph G EM
324 Tinsman Ave
Williamsport PA 17701
FAJARDO, MD, Arturo A R
1035 Canterbury Rd
Williamsport PA 17701
FAMORCA, MD, Florentino P GS
1016 Washington Blvd
Williamsport PA 17701

FENNER, MD, Henry E PTH
601 S Main St
Muncy PA 17756
FERNANDEZ, MD, Eduardo I AN
R D 3 Box 340
Montoursville PA 17754
FINKELSTEIN, MD, Herman IM
215 6010 Falls Cirle S
Lauderhill FL 33319
FINN, MD, David R PUD
777 Rural Ave
Williamsport PA 17701
FINN, MD, Martha J B IM
904 Campbell
Williamsport PA 17701
FISSEL, MD, George E R
P O Box 175
Pinehurst NC 28374
FORCEY, MD, Lloyd R GP
116 Kerr Ave
Jersey Shore PA 17740
FORD, MD, William T D
699 Rural Ave
Williamsport PA 17701
FORKER, MD, Thomas S FP
990 Thompson Street
Jersey Shore PA 17740
FRANKEL, MD, Gerald J U
425 Market Street
Williamsport PA 17701
FREYNIK, MD, Joseph G FP
699 Rural Ave
Williamsport PA 17701
FRIES, MD, Gene T PTH
777 Rural Ave
Williamsport PA 17701
FUNK JR, MD, F Coleman FP
R D 5
Muncy PA 17756
GANDY, DO, Daniel R NEP
1205 Grampian Blvd
Williamsport PA 17701
GEHRON JR, MD, William H U
747 Arch Street
Williamsport PA 17701
GEORGY, MD, Farouk M OBG
528 W Fourth St
Williamsport PA 17701
GINTER JR, MD, George C AN
R D 5 Box 256
Williamsport PA 17701
GO, MD, Alfonzo H L AN
R D 2 Box 105-B
Montoursville PA 17754
GOULDIN, MD, Judith A NM
Williamsport Hosp
Williamsport PA 17701
GRABOYES, MD, Arnold B IM
Williamsport Hosp E R
Williamsport PA 17701
GREENE, MD, Donald H ORS
1020 Thompson St
Jersey Shore PA 17740
HAMM, MD, William G EM
2440 Blair St
Williamsport PA 17701
HAMOY, MD, Alice G IM
116 Kerr St
Jersey Shore PA 17740
HAMOY, MD, George L EM
R D 2 Box 870
Jersey Shore PA 17740
HARRISON, MD, James L CDS
699 Belmont Ave
Williamsport PA 17701
HARTZ, MD, Leo M FP
27 S Washington St
Muncy PA 17756
HAYES, MD, Warren H FP
2116 W Fourth St
Williamsport PA 17701
HEARTER JR, MD, William R DR
Dept Of Rad Williamsport Hosp
Williamsport PA 17701
HEERE, MD, Barbara A IM
1505 Ritchey St
Williamsport PA 17701
HEINBACH JR, MD, Robert A OBG
1201 Woodmont Avenue
Williamsport PA 17701
HENDERSON, MD, K Wayne ND
1205 Grampian Blvd
Williamsport PA 17701
HEYMAN, MD, David Coleman AN
862 Rural Ave
Williamsport PA 17701
HILL, MD, Daniel E CLP
Williamsport Hosp
Williamsport PA 17701
HIPPLE, MD, Randall F OBG
528 W Fourth St
Williamsport PA 17701
HOFSTROM, MD, Glen T FP
145 Shaffer St
Williamsport PA 17701
HONG, MD, Soo W OTO
699 Rural Ave
Williamsport PA 17701
HURST, MD, Kenneth L FP
1205 Grampian Blvd
Williamsport PA 17701

JACQUES, MD, Charles H FP
1626 Elliott Street
Williamsport PA 17701
JENNINGS, MD, David T OPH
1510 Elliott St
Williamsport PA 17701
JOHN EXEC, DIR, Paul P US
2895 Euclid Ave
Williamsport PA 17701
JONES JR, MD, John H GS
300 Grove Street
S Williamsport PA 17701
JUDSON, MD, Susan C HEM
R D 3 Box 136
Williamsport PA 17701
JUDSON, MD, William W IM
904 W Fourth St
Williamsport PA 17701
KAAR, MD, Richard C GP
603 Center St
Milton PA 17847
KAISER, MD, Ralph H PD
2430 Sheridan St
Williamsport PA 17701
KEATING, MD, Edward C CD
777 Rural Ave
Williamsport PA 17701
KIM, MD, II G GS
R D 1 Med Arts Bldg
Hughesville PA 17737
KLIM, DO, Gerald V P
777 Rural Ave
Williamsport PA 17701
KOLB, MD, Aaron J FP
1205 Grampian Blvd
Williamsport PA 17701
KOLB, MD, Charles E OPH
R D 3 Box 153
Cogan Station PA 17728
LARSON JR, MD, Theodore S R
1200 Campbell St
Williamsport PA 17701
LATTIMER, MD, Gary L ID
699 Rural Ave
Williamsport PA 17701
LEBER, MD, Paul E EM
1205 Grampian Blvd
Williamsport PA 17701
LECHNER, MD, Frederic C IM
331 Center St
Williamsport PA 17701
LEVAN, MD, Melodee S FP
699 Rural Avenue
Williamsport PA 17701
LIDDELL, MD, Albert G ORS
1201 Grampian Blvd
Williamsport PA 17701
LIPSON, MD, Stephen D U
904 Campbell Street
Williamsport PA 17701
LUBBE, MD, Willem J PTH
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Williamsport PA 17701
LUKAS, MD, Raymond A AN
R D 2 Box 289-A
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Williamsport PA 17701
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Port St Lucie FL 33452
MANCHESTER, MD, George A FP
R D 2 Box 259
Williamsport PA 17701
MANNING, MD, Harry L N
699 Rural Ave
Williamsport PA 17701
MARIANO JR, MD, Tomas A GS
P O Box 5107
Jersey Shore PA 17740
MAYS, MD, Richard R P
R D 2 Box 57
Muncy PA 17756
MCCAULEY, MD, William C PUD
777 Rural Ave
Williamsport PA 17701
MEHTA, MD, Pankaj OBG
1205 Grampian Blvd
Williamsport PA 17701
MIGLIORE, MD, Joseph J EM
528 Rural Avenue
Williamsport PA 17701
MILLER, MD, Earl R OS
807 Curtin St
S Williamsport PA 17701
MIRZA, MD, Mohammad R CD
1201 Grampian Blvd
Williamsport PA 17701
MONTAGUE, MD, James W FP
R D 1
Montoursville PA 17754
MORENO, MD, Manuel V AN
Divine Providence Hospital
Williamsport PA 17701
MOSER, MD, Edward N GS
699 Rural Ave
Williamsport PA 17701
MURPHY, MD, Edith L OS
2609 Waldman Dr
Williamsport PA 17701

NAGEL, MD, David B TR
1100 Grampian Blvd
Williamsport PA 17701
NAIDU, MD, Jai P PD
335 Maynard St
Williamsport PA 17701
NELSON, MD, Philip K OBG
4773 Greencroft Rd
Sarasota FL 33580
NEWBURY, MD, Robert O GP
P O Box 66
Loganton PA 17747
NIELSEN, MD, R Craig FP
736 High St
Williamsport PA 17701
NIERLE, MD, Richard H GP
95 E Houston Ave
Montgomery PA 17752
OLINSKY, MD, Stuart M N
425 Market St
Williamsport PA 17701
PAGANA, MD, Timothy J ON
1205 Grampian Blvd
Williamsport PA 17701
PARK, MD, Young Won PM
777 Rural Ave
Williamsport PA 17701
PATEL, MD, Harshad R ri
1100 Grampian Blvd
Williamsport PA 17701
PECK, MD, William J FP
1205 Grampian Blvd
Williamsport PA 17701
PEPPERMAN, MD, Larue E EM
807 Grampian Blvd
Williamsport PA 17701
PETERS II, MD, C A P FP
5 English Hill R D #3
Cogan Station PA 17728
PETERSON, MD, Glenn R P
1100 Grampian Blvd
Williamsport PA 17701
PFEIL, MD, Russell W GP
264 Broad St
Montoursville PA 17754
POLIS, MD, Mark J U
1205 Grampian Blvd
Williamsport PA 17701
POPHAL, MD, Mahlon J PTH
1495 Princeton Ave
Williamsport PA 17701
POWERS JR, MD, Francis M TR
1100 Grampian Blvd
Williamsport PA 17701
QUERIMIT, MD, Jorge A GS
699 Rural Ave
Williamsport PA 17701
RAJJOUB, MD, Rodwan K NS
699 Rural Ave
Williamsport PA 17701
RANNELS, MD, Herman W OS
R D 1 Box 45-A
Marietta PA 17547
RATKE, MD, Henry V GP
115 Lina Ln
Martinsburg WV 25401
REDDY, MD, Rajidi M CD
Muncy Valley Hosp
Muncy PA 17756
REDKA, MD, James W FP
1205 Grampian Blvd
Williamsport PA 17701
REIS, MD, Paul B TS
25 W Third St
Williamsport PA 17701
RODGERS, MD, Charles J GP
511 W Fourth St
Williamsport PA 17701
SALVATORE, MD, Michael A PUD
215 Grampian Blvd
Williamsport PA 17701
SANFORD, MD, Frederic E OS
625 Harding Ave
Williamsport PA 17701
SCHOPFER, MD, Ralph E AN
712 Vallamont Dr
Williamsport PA 17701
SCHWARTZ, MD, Sheldon M PTH
777 Rural Ave
Williamsport PA 17701
SCHWEIKLE, MD, Mary R GE
1205 Grampian Blvd
Williamsport PA 17701
SERVOSS, MD, Spencer J U
17 Round Hill Rd
Williamsport PA 17701
SHAFIQUE, MD, Mohammad CD
1201 Grampian Blvd
Williamsport PA 17701
SHAW, MD, Gordon A DR
Williamsport Hosp
Williamsport PA 17701
SHEARER, MD, Donald E GP
217 Broad St
Montoursville PA 17754
SHENBERGER, MD, Keith N RHU
1205 Grampian Blvd Ste 1-B
Williamsport PA 17701
SHU, MD, Chia S OBG
1205 Grampian Blvd
Williamsport PA 17701

SILVERMAN, MD, Morton L EM
503 Seminole Gardens
Ambler PA 19002
SINCLAIR, MD, Sydney E OS
608 Highland Terrace
Williamsport PA 17701
SOMERS, MD, William R IM
1205 Grampian Blvd
Williamsport PA 17701
SORBER, MD, William A IM
211 E Water Street
Muncy PA 17756
SOUNDARARAJAN, MD, GS
Ranganatha
777 Rural Ave
Williamsport PA 17701
SPINNEY, MD, Carmen E IM
Box A
Avis PA 17721
SRINIVASAN, MD, Venkatraman CD
1205 Grampian Blvd
Williamsport PA 17701
STEVENS, MD, Robert G PM
777 Rural Ave
Williamsport PA 17701
STEWART, MD, James A PD
65 N Main St
Montgomery PA 17752
STONE, MD, Walker H GS
989 Country Club Dr
Williamsport PA 17701
STORY, MD, Nancy S FP
1201 Grampian Boulevard
Williamsport PA 17728
STRALEY, MD, Richard K ORS
1201 Grampian Blvd
Williamsport PA 17701
SUTER, MD, Harry J CD
699 Rural Ave
Williamsport PA 17701
SUTLIFF, MD, Charles S PM
R D 3
Montoursville PA 17754
TAYLOR, MD, Arthur R FP
699 Rural Ave
Williamsport PA 17701
TIGNOR, MD, Richard F OPH
699 Rural Ave
Williamsport PA 17701
TOBIAS, MD, Richard B GER
1615 Riverside Dr
Williamsport PA 17701
TODHUNTER, MD, William D GS
699 Rural Ave
Williamsport PA 17701
TUFFAHA, MD, Hani J NS
904 Campbell St
Williamsport PA 17701
UPDEGROVE, MD, Robert A OTO
699 Rural Ave
Williamsport PA 17701
VANDERLIN, MD, Robert L US
414 Locust St
Williamsport PA 17701
VASUDEVAN, MD, Raghavan CD
1001 Grampion Blvd
Williamsport PA 17701
WADE, MD, Franklin G GS
1305 Campbell St
Williamsport PA 17701
WAGNER, MD, W John GP
217 Broad St
Montoursville PA 17754
WASILEWSKI JR, MD, Charles L D
1201 Grampian Blvd
Williamsport PA 17701
WEANER JR, MD, Howard H FP
11 N Main St
Montgomery PA 17752
WEAVER, MD, Don K PTH
777 Rural Ave
Williamsport PA 17701
WETSTONE, MD, Jeffrey B FP
699 Rural Ave
Williamsport PA 17701
WILCOX, MD, Wilfred W GP
531 Broad St
Montoursville PA 17754
WILLIAMS, MD, A Claude P
R 915 5Th Ave
Williamsport PA 17701
WILLIAMS, MD, Robert H PD
699 Rural Ave
Williamsport PA 17701
WILLIAMSON, MD, Neihl J FP
111 Oliver St
Jersey Shore PA 17740
WINTER 2ND, MD, John C A
416 Pine St
Williamsport PA 17701
WITTHOFF JR, MD, Elmer M FP
306 Allegheny St
Jersey Shore PA 17740
WOLFE, MD, Daniel E R
800 Grampian Blvd
Williamsport PA 17701
WOROBEC, MD, Russell N ORS
1201 Grampian Blvd
Williamsport PA 17701
YASUI, MD, Robert S GS
1001 Grampian Blvd
Williamsport PA 17701

YEALY, MD, W Holmes DR
R D 4 Box 610
Muncy PA 17756
YOON, MD, Chan R
1100 Grampian Blvd
Williamsport PA 17701
ZELLER, MD, Robert G DR
316 W Fourth St
Williamsport PA 17701

MCKEAN

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64 Walker Ave
Bradford PA 16701
BENTZ, MD, Charles R GP
Two Thompson Park
Kane PA 16735
BOWMAN JR, MD, Douglas F GP
P O Box 443
Smethport PA 16749
CLELAND, MD, Charles E A
106 S Fraley St
Kane PA 16735
CLELAND, MD, M Elizabeth PD
106 S Fraley St
Kane PA 16735
CORCORAN, MD, James R
Bradford Hosp
Bradford PA 16701
DEE, MD, Cecilio C PTH
Bradford Hosp
Bradford PA 16701
FOKSTUEN, MD, Terje S P
137 N Bennett St
Bradford PA 16701
GABRIEL, MD, Frederick R R
Five Brown Ave
Bradford PA 16701
GUENTER, MD, Fritz E ABS
Temple Club Bldg
Smethport PA 16749
HAMIDI, MD, Jafar A OBG
199 Pleasent St 21
Bradford PA 16701
HENRY, MD, Walter J OBG
7344 E Rose La
Scottsdale AZ 85253
IBANEZ, MD, Melchisedec GS
35 Hemlock Ave
Kane PA 16735
JACOBS, MD, Martin IM
Rm 406 Hooker Fulton Bldg
Bradford PA 16701
JAMIL, MD, Qazi A US
Med Arts Bldg Ste 22
Bradford PA 16701
JUNG, MD, Tinliung OBG
Med Arts Bldg
Bradford PA 16701
KONWINSKI, MD, Edward S GS
305 Hooker Fulton Bldg
Bradford PA 16701
KRALL, MD, Robert P GS
47 Elm St
Eldred PA 16731
MEDDEN, MD, Edwin J GS
125 Main St
Bradford PA 16701
NADELLA, MD, Venkateswara R EM
Bradford Hosp
Bradford PA 16701
NAYAK, MD, Narayan PD
Med Arts Bldg
Bradford PA 16701
NILES, MD, Robert A GP
Willow St
Port Allegany PA 16743
OCAMPO, MD, Renato G GS
S Edgar St
Kane PA 16735
OLSON, MD, Dennis A FP
103 Pine Ave
Kane PA 16735
OSBORNE, MD, David P GS
R D 1 Back Acres
Smethport PA 16749
PITKIN, MD, John T CHP
620 W Main St
Smethport PA 16749
PRADHAN, MD, Anil G PD
199 Pleasant St Med Bldg
Bradford PA 16701
ROCHE JR, MD, Edward J FP
Rm 406 Hooker Fulton Bldg
Bradford PA 16701
SANKARI, MD, Muhammed A GS
103 Dennis Ave
Port Alleghany PA 16743
SAQUIN, MD, Raineldo C PTH
103 Hemlock Ave
Kane PA 16735
SARAJEDINI, MD, Hossain U
42 Parkway Lane
Bradford PA 16701
SCHECTER, MD, Benjamin C GS
723 East Main Street
Bradford PA 16701
SICHER, MD, Bruno P FP
133 Biddle St
Kane PA 16735
SILVERSTINE, MD, Leslie B PD
1085 Gulf Of Mexico Dr
Longboat Key FL 33548
SINGH, MD, Dilbagh EM
116-156 Interstate Pkwy
Bradford PA 16701
SONI, MD, Gurbax S EM
80 Gregory Ave
Bradford PA 16701
STILL, MD, George J CD
199 Pleasant St
Bradford PA 16701
VALDES, MD, Conrado A AN
Community Hosp
Kane PA 16735
WATKINS, MD, Donald R GS
125 Main St
Bradford PA 16701
WHITE, MD, Robert E IM
201 Hooker Fulton Bldg
Bradford PA 16701

MERCER

ALLEN, MD, Robert W R
Med Arts Bldg
Sharon PA 16146
AYE, MD, J Thomas ORS
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Sharon PA 16146
AYULO, MD, Marco A IM
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Howland OH 44484
BAILEY, MD, Nelson J OS
61 E Main St
Sharpsville PA 16150
BAKER, MD, Robert H ORS
428 S Main St
Greenville PA 16125
BALING, MD, Larry E IM
2151 Shenango Valley Frwy
Hermitage PA 16148
BASHLINE, MD, Don L GS
Grove Cty Hosp Med Bld 1
Grove City PA 16127
BASHLINE, MD, H Woodrow GP
R D 1
Grove City PA 16127
BATAILLE, MD, Jacques A IM
1808 Mcdowell St
Sharon PA 16146
BAYUK, MD, John D FP
805 Fairfield Dr
Hermitage PA 16146
BECK, MD, Donald E OBG
103 Vine Ave
Greenville PA 16125
BEH, MD, Walter P U
81 N Main Street
Greenville PA 16125
BEHRENDT, MD, Richard P OBG
604 Fourth St
Butler PA 16001
BERMUDEZ, MD, Armand J PUD
1921 Shenango Valley Freeway
Hermitage PA 16148
BODNAR, MD, Timothy J EM
740 E State Street
Sharon PA 16146
BOLOTIN, MD, Joseph H IM
1126 E State St
Sharon PA 16146
BREVETTA, MD, Richard J OPH
719 E State St
Sharon PA 16146
BROWN, MD, Matthew G FP
Med Arts Bldg
Sharon PA 16146
BROWN, MD, William E OTO
1260 E State St
Sharon PA 16146
BUISER, MD, Rodolfo A EM
110 N Main St
Greenville PA 16125
BUTCHKO, MD, Andrew W IM
67 Jefferson Ave
Sharon PA 16146
CHARLTON, MD, Glenn B FP
912 State St
Sharon PA 16146
CHATHA, MD, Iftikhar A FP
3336 E State St
Hermitage PA 16148
COHEN, MD, Donald L PTH
Sharon Gen Hosp
Sharon PA 16146
COLAIACO, MD, Victor I IM
90 Sherango St
Greenville PA 16125
CONLIN, MD, Edward F IM
486 Forker Boulevard
Sharon PA 16146
CONNELLY, MD, Michael E CRS
902 Linden St
Sharon PA 16146
CRAGO, MD, H Robert GS
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DAMORE, MD, David L IM
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Sharon PA 16146
DOBLE II, MD, Henry P OTO
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DONAN, MD, Anderson W FP
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DOWDELL, MD, Paul J A
90 Shenango St
Greenville PA 16125
FALK, MD, Edward C GS
32 Jefferson Ave
Sharon PA 16146
FILE, MD, James C GP
Linden & Lake Sts
Stoneboro PA 16153
FLAMBERG, MD, Ira W AN
950 Forest Ln
Sharpsville PA 16150
GARRIOTT, MD, John C DR
108 Med Arts Bldg
Sharon PA 16146
GREENBURG, MD, Morren J FP
3348 E State St
Sharon PA 16146
HAM, MD, Tong H FP
701 N Hermitage Rd
Sharon PA 16146
HARRER JR, MD, William J EM
1109 Highland Rd
Sharon PA 16146
HOLT, MD, Allen H R
32 Jefferson Ave
Sharon PA 16146
JONES, MD, Tom B DR
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KO, MD, Yih Song GP
421 Shady Dr
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KOLENICH, MD, James J GS
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LALLY, MD, Francis L IM
2815 Woodhill Dr
Hermitage PA 16148
LARTZ, MD, Robert E GYN
601 Carley Ave
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LIM, MD, Lourdes T OBG
C/O Dr Limkakeng Med Ctr
Grove City PA 16127
LIMKAKENG, MD, Alexander D U
Hillcrest Med Ctr
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LUCHETTE, MD, Albert A GS
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Sharon PA 16146
MADURA, MD, Joseph R GP
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Farrell PA 16121
MARTSOLF, MD, Robert H FP
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MCPARLAND, MD, John J EM
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MCWHIRTER, MD, William R ORS
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Greenville PA 16125
MEHTA, MD, Sunil K IM
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SHIELDS, MD, Thomas J OBG
S Broad St & Allentown Rd
Lansdale PA 19446
SHIN, MD, Grace E AN
1415 Wahington Ln
Rydal PA 19046
SHISLER, MD, Frederick H GP
Lansdale Clinic
Lansdale PA 19446
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256 S York Road
Hatboro PA 19040
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1234 Fillmore St
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Green Valley Farm
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Lansdale PA 19446
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SILVERS, MD, Abigail A ON
933 Haverford Rd
Bryn Mawr PA 19010
SIMOES, MD, Antonio J GS
401 Bonnie Ln
Lansdale PA 19446
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1464 Ft Washington Ave
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SINGH, MD, Sawraj GS
Holy Redeemer Hosp
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SIVITZ, MD, Michael C PD
1047 Old York Road
Abington PA 19001
SKOWRONSKI, MD, Theodore J IM
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Abington PA 19001
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543 Oak Shade Ave
Elkins Park PA 19117
SMITH, MD, Mary L IM
902 West Ave
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SMITH, MD, Robert W CD
Rydal And Clement Rds
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1244 Ft Washington Ave
Ft Washingtn PA 19034
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102 Cherokee Cir
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312 King St
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1116 Shaw Dr
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Bryn Mawr PA 19010
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ARGENIO, MD, Sandra L FP
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AWAD, MD, Latif L OBG
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AYRES, MD, John R GS
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BAKER, MD, Jeffrey H FP
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BAKER, MD, Kenneth M CD
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BATES, MD, James S OBG
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R D 1
Sunbury PA 17801
BEILER, MD, David D TR
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BENKOVIC, MD, Gregory W IM
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BENOIT, MD, Charles H TS
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BERNATH JR, MD, Albert M ON
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BETZ, MD, William R IM
735 Grovania Dr
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BHATIA, MD, Shyamsunder D
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BRILL, MD, David R NM
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BROTMAN, MD, Sheldon TRS
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CARLSON, MD, John P N
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Danville PA 17822
CASSIDY, MD, Harvey D FP
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CERA JR, MD, Peter J PTH
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Danville PA 17822
CLEMENT, MD, John A TR
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COHN, MD, Gerald H N
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COLANCECCO, MD, Joseph P IM
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38 Overlook Dr
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COLLEY, MD, Arthur T IM
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Danville PA 17822
NATIVIDAD, MD, Nita C TR
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Danville PA 17821
OROURKE, MD, John N A
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Danville PA 17821
PARENTI, MD, John M ORS
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Danville PA 17821
PHARR, MD, William F CDS
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REAMS, MD, Carl L OT
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RICHARD, MD, David C FP
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ROMMEL, MD, Catherine T OPH
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ROSE, MD, John F U
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Danville PA 17821
ROTHERMEL, MD, Franklin J R
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Danville PA 17821
ROYER, MD, Thomas C EM
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Danville PA 17821
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SPILSBURY, MD, Paul R N
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STARKEY, MD, Ralph H END
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Danville PA 17822
STETZ, DO, Drew J OTO
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114 Pine Ridge Dr
Pine Grove PA 17963
PERLOSKI, MD, Leo GP
Washington St
Middleport PA 17953
PIERDON, MD, Steven B PD
316 Mauch Chunk St
Pottsville PA 17901
PLATT, MD, Benjamin B IM
016 S Claude A Lord Blvd
Pottsville PA 17901
PRISTAS, MD, Michael S FP
602 W Market St
Pottsville PA 17901
PUJARA, MD, Mahendra M U
410 W Market St
Pottsville PA 17901

QUDDAS, MD, Abdul I IM
130 Country Hill Road
Orwigsburg PA 17961
QUDDUS, MD, Adeeba S PD
Medical Arts Building
Pottsville PA 17901
RASHID, MD, Abdul IM
106 S Claude A Lord Blvd
Pottsville PA 17901
RAVITZ, MD, Gerald A U
413 W Market St
Pottsville PA 17901
REITZ, MD, Melvin L GP
Valley View PA 17983
RICCHIUTI, MD, A George OPH
335 Center St
Mahanoy City PA 17948
RICCHIUTI, MD, Joseph F A
307 W Market St
Pottsville PA 17901
RISMILLER, MD, Ross W IM
214 W Market St
Pottsville PA 17901
RITTER, MD, Thomas J GS
407 W Market St
Pottsville PA 17901
ROBINSON, MD, James P EM
44 E Main St
Tremont PA 17981
ROMEIKA, MD, Mary M FP
14 N Jardin St
Shenandoah PA 17976
RUBRIGHT, MD, Herbert C GP
E Main St Med Arts Bldg
Schuylkill Haven PA 17972
RUBRIGHT JR, MD, Herbert C FP
E Main St Med Arts Bldg
Schuylkill Haven PA 17972
RUSSO, MD, John F CLP
Good Samaritan Hosp
Pottsville PA 17901
RYSCAVAGE, MD, Edward T GP
100 S Second St
St Clair PA 17970
SAFDAR-ALI, MD, Mohammad EM
30 S Jardin St
Shenendoah PA 17976
SAHOO, MD, Dilliswar IM
Po Box 25
Coaldale PA 18218
SCHLITZER, MD, William H GP
1247 W Norwegian St
Pottsville PA 17901
SCHWARTZ, MD, Ira U
413 W Market St
Pottsville PA 17901
SCICCHITANO, MD, Leon P GS
Seventh & W Market Sts
Pottsville PA 17901
SHAH, MD, Syed G IM
Medical Arts Bldg
Pottsville PA 17901
SINGH, MD, Rajendra PDA
Medical Arts Building
Pottsville PA 17901
SLATON, MD, Stephen S GS
715 Center St
Ashland PA 17921
STANULONIS, MD, Stanley W IM
25 N Jardin St
Shenandoah PA 17976
TANANIS, MD, Leonard J OPH
610 W Market St
Pottsville PA 17901
TAVARIA, MD, Soli IM
327 Sunbury St
Minersville PA 17954
TIHANSKY, MD, Theodore B HYP
Med Arts Bldg
Schuylkill Haven PA 17972
TOMLIN, MD, Joseph GP
17 S Main St
Shenandoah PA 17976
WAHHAB, MD, Abdul GS
106 S Claude A Lord Blvd
Pottsville PA 17901
WALL, MD, Norman M IM
One Norwegian Plaza
Pottsville PA 17901
WALTERS, MD, William H GP
614 Mahantongo St
Pottsville PA 17901
WANG, MD, Yung-Wen EM
201 N Second Street
Girardville PA 17935
YANKOSKY, MD, Jean A FP
109 Pike St
Port Carbon PA 17965
ZAFAR, MD, Ghaffar A PD
106 S Claude A Lord Blvd
Pottsville PA 17901
ZAKHARY, MD, George OTO
300 S Center St
Pottsville PA 17901
ZWERLING, MD, Hermann GP
100 E Main St
Schuylkill Haven PA 17972

SOMERSET

ATWELL, DO, Grant E FP
132 Meyers Avenue
Meyersdale PA 15552

ATWELL II, DO, Grant E GP
Ord St Salisbury Prof Bldg
Salisbury PA 15558
BACESKI, MD, Deborah A IM
105 W Church St
Somerset PA 15501
BHASKAR, MD, Ambat G PTH
225 S Center Ave
Somerset PA 15501
CHARLESWORTH, MD, Ernest E FP
453 West Patriot Street
Somerset PA 15501
CHAVES, MD, Fernando AN
225 S Center Ave
Somerset PA 15501
CUBE, MD, Henry M NS
332 W Patriot St
Somerset PA 15501
DEVRIES, MD, Jan R FP
305 Stonycreek St
Boswell PA 15531
GADIPARTHI, MD, Atchaiah OTO
118 S Center Avenue
Somerset PA 15501
HAY, MD, Harold S GP
867 W Main St
Somerset PA 15501
JACOBS, MD, Robert V GS
203 E Patriot St
Somerset PA 15501
KAWCHAK, MD, James IM
721 North St
Berlin PA 15530
KILLIUS, MD, James L GP
314 Diamond St
Berlin PA 15530
KLOSE, MD, Paul L FP
P O Box 196
Berlin PA 15530
LEIGHTY, MD, Ralph G IM
9001 Kings Road
Myrtle Beach SC 29577
LIMCUANDO, MD, Emiliano D GS
401 S Center Ave
Somerset PA 15501
MARTIN, DO, Elvin L FP
202 Beachley Street
Meyersdale PA 15552
MCKEE, MD, Wayne O GS
R D 4 Box 50
Somerset PA 15501
MILLER, MD, Thomas L FP
202 Beachley
Meyersdale PA 15552
MONTGOMERY JR, MD, U
George A
107 E Church Street
Somerset PA 15501
MORRIS, MD, Eleanor G GP
R D 4 Box 231
Somerset PA 15501
MUSSER JR, MD, Harold E EM
105 W Church St
Somerset PA 15501
NAIR, MD, V Krishnan CD
225 S Center Ave
Somerset PA 15501
NAYAK, MD, Satish R OBG
756 Farragut St
Johnstown PA 15905
ORLIDGE, MD, Arthur E GP
Box 141 North St
Shanksville PA 15560
PEIRSEL, MD, Paul E FP
P O Box 147
Friedens PA 15541
PELL III, MD, Edward N GS
339 W Union St
Somerset PA 15501
PESSOLANO, MD, Francis X DR
Sommerset Community Hospital
Somerset PA 15501
PESSOLANO, MD, Frank J EM
R D 1 Box 329
Somerset PA 15501
POGGI, DO, Alfred J GP
R D 3 Hickory Hollow Rd
Somerset PA 15501
PRICE, MD, Edwin M GP
612 Logan Pl
Confluence PA 15424
ROCK, MD, Leonard L GP
209 North St
Meyersdale PA 15552
RUMBAUGH, MD, Ross S GS
131 Meyers Avenue
Meyersdale PA 15552
RYAN, MD, William C P
917 W Main St
Somerset PA 15501
SANTOS, MD, Rodolfo R GP
229 Dale St Box 157
Meyersdale PA 15552
SHARIAT, MD, Iraj OPH
118 S Center Ave
Somerset PA 15501
SINGH, MD, Ajay P PD
614 S Franklin Ave
Somerset PA 15501
TENSUAN JR, MD, Leonardo S IM
433 W Main Street
Somerset PA 15501

THOMAS, MD, Nathan O FP
349 Main St
Meyersdale PA 15552
WONG, MD, Albert OBG
225 S Center Avenue
Somerset PA 15501
WOOLSLAYER, MD, Paul R GP
208 Sherman St
Meyersdale PA 15552
ZADEH, MD, Habib T ORS
164 E Church St #4
Somerset PA 15501

SUSQUEHANNA

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BERTSCH, MD, Albert M GS
1 Grow Ave
Montrose PA 18801
CAVENDER, MD, John C GP
P O Box 213
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DAVIS, MD, Raymond C GP
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GRACE, MD, James J GP
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Montrose PA 18801
HENNING III, MD, George F FP
R D 1 Box 368-A
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HOMILY, MD, Blessing B GS
Med Arts Clinic
Montrose PA 18801
KERR, MD, Paul B FP
1 Grow Ave
Montrose PA 18801
LEONARD, MD, Michael E FP
Hallstead Plaza Box K
Hallstead PA 18822
MANLEY, MD, Charles R AN
1 Grow Ave
Montrose PA 18801
MARKARIAN, MD, Michael FP
220 Main St
Hallstead PA 18822
MILLER, MD, James M IM
78 Church St
Montrose PA 18801
PURKAYASTHA, MD, Arindam GS
Box 241
Susquehanna PA 18847
SARAN, MD, Madhukar PUD
104 Jackson Ave
Susquehanna PA 18847
SHAH, MD, Mahendra K IM
308 Broad Ave
Susquehanna PA 18847
SHELLY, MD, Robert M OS
R D 2 Box 324
Susquehanna PA 18847

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BUTLER, MD, Anne K GP
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CALLENBERGER, MD, ORS
Ronald W
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CHEADLE, MD, Margaret J FP
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Wellsboro PA 16901
COOLIDGE, MD, William A GP
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DALE II, MD, Leonard E R
Soldiers & Sailors Hosp
Wellsboro PA 16901
DAVIES, MD, Thomas E GS
48 Pearl St
Wellsboro PA 16901
DAVIS, MD, Murray C DR
13 Berwart St
Wellsboro PA 16901
DAVIS, MD, Stuart M GP
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Westfield PA 16950
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25 Walnut St
Wellsboro PA 16901
GAFFORD, MD, Grady D OPH
15 Meade St
Wellsboro PA 16901
GILLUM, MD, David F FP
P O Box 814 114 East Ave
Wellsboro PA 16901

HESS, MD, Edward R GS
38 West Ave
Wellsboro PA 16901
HUNTER, MD, Carol A FP
3210 Carbon St #77
Whitehall PA 18052
LAIRD, MD, Archibald OPH
12 Main St
Wellsboro PA 16901
LARSON, MD, Eleanor GP
217 Main St
Elkland PA 16920
MICHAEL, MD, Donald J P
57 Extension St
Mansfield PA 16933
MOORE, MD, Joseph J CD
38 Prospect St
Mansfield PA 16933
NESPOLA, MD, Anthony M IM
15 Meade St
Wellsboro PA 16901
PORT, MD, Brian R FP
11 W Main St
Galeton PA 16922
REICH, MD, William P PTH
18 Morris Ln
Wellsboro PA 16901
SANFORD, MD, Robert S GP
40 W Wellsboro St
Mansfield PA 16933
SHAW, DO, Donald D FP
114 East Ave
Wellsboro PA 16901
SWAGLER, DO, Curtis P GP
114 East Ave
Wellsboro PA 16901
THOMAS, MD, F Ardell IM
15 Meade St
Wellsboro PA 16901
WEBSTER, MD, Lane FP
Walnut St
Wellsboro PA 16901
WIGERT, MD, Walter S P
P O Box 8
Blossburg PA 16912
WILSON, MD, James L GP
25 Walnut St
Wellsboro PA 16901

UNION

ARBOGAST JR, MD, John W OBG
Three Hospital Dr
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ARBOGAST SR, MD, John W GS
40 S Second St
Lewisburg PA 17837
BERNSTEIN, MD, Robert OPH
Three Hospital Dr
Lewisburg PA 17837
BETZ, MD, Louis H OPH
Three Hospital Dr
Lewisburg PA 17837
BRUCE, MD, William B OTO
Three Hospital Dr
Lewisburg PA 17837
CALDERON, MD, Amador G GS
603 Pennsylvania St
Lewisburg PA 17837
DAVIS, MD, Sidney D
48 Walnut St
Milton PA 17847
DERR, MD, Frederick S GP
804 Market St
Mifflinburg PA 17844
DIX JR, MD, Robert C FP
131 Broadway
Milton PA 17847
EVANS, MD, Harold H GP
422 Market St
Mifflinburg PA 17844
FAIRWEATHER, MD, Jack L OBG
129 Market Street
Lewisburg PA 17837
GINSBURG, MD, John L FP
134 S 16th St
Lewisburg PA 17837
GRAY, MD, David W GS
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Lewisburg PA 17837
HAHN, MD, Jonathan F ORS
900 Buffalo Rd
Lewisburg PA 17837
HOYLE, MD, J Preston PD
Ziegler Dispensary
Lewisburg PA 17837
LANG, MD, Kathie J FP
Six Country Rd
Lewisburg PA 17837
LONG, MD, Robert D D
Three Hospital Dr
Lewisburg PA 17837
MALCOLM JR, MD, John A PTH
R D 1
Sunbury PA 17801
MILLER II, MD, George C OBG
Three Hospital Dr
Lewisburg PA 17837
MORGAN JR, MD, James W GS
Three Hospital Dr
Lewisburg PA 17837
MUSSER, MD, William T GP
100 Chestnut St
Mifflinburg PA 17844
MUSSOLINE, DO, Joseph F GP
Buffalo Valley Shopping Ctr
Mifflinburg PA 17844
NISSLEY, MD, Jay M PD
136 Hospital Dr
Lewisburg PA 17837
PERSING, MD, John H IM
R D 1
Lewisburg PA 17837
REGALADO, MD, Regulus D GS
714 R Main St
Watsontown PA 17777
REISH, MD, William G ORS
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Lewisburg PA 17837
RINCK II, MD, George W EM
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Middleburg PA 17842
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P O Box 262
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RUSSIN, MD, Mary S R
150 Jean Boulevard
Lewisburg PA 17837
STACKOWSKI, MD, Maryjane R
Evangelical Comm Hosp
Lewisburg PA 17837
STECKEL, MD, Donald C IM
R D 1 Spruce Hills
Lewisburg PA 17837
STOLTZFUS, MD, Elam R P
136 Hospital Dr
Lewisburg PA 17837
SWALLOW, DO, William B US
130 S Front St
Milton PA 17847
TEICHMAN, MD, Fred OBG
148 Mountain View Rd
Lewisburg PA 17837
VELAYO, MD, Dante P US
Three Hospital Dr
Lewisburg PA 17837
WARD, MD, H Richard GP
R D 1
Mifflinburg PA 17844
WEBER, MD, William H US
Box 336
Middleburg PA 17842
WEIBEL, MD, David C U
Three Hospital Dr
Lewisburg PA 17837
WEIGHTMAN, MD, Joseph OS
Bucknell Univ Dispensary
Lewisburg PA 17837
WENTZLER, MD, J Donald AN
Box 275
Watsontown PA 17777
WILLIAMS III, MD, Irving AN
R D 1 Box 206
Lewisburg PA 17837
WOODCOCK, MD, Charles H EM
342 N Front St
Milton PA 17847
YANNACCONE, MD, Robert GP
611 Main St
Watsontown PA 17777
ZUG, MD, P Ronald IM
3 Hospital Drive
Lewisburg PA 17837

VENANGO

ANDERSON, MD, William C EM
R D 1 Pone Ln
Franklin PA 16323
ANTHONY, MD, Jonathan M AN
Franklin Hosp
Franklin PA 16323
ANTKOWIAK, MD, Thomas L ORS
181 Park Avenue
Franklin PA 16323
AOUN, MD, Kamal H FP
515 Green Bldg
Franklin PA 16323
BARNES, MD, Barbara E IM
Titusville Hosp
Titusville PA 16354
BAUM, MD, Neil B FP
One Spruce St
Franklin PA 16323
BEALS, MD, Norman K CHP
621 Plumer Ave Miller Park
Franklin PA 16323
BELL JR, DO, Joseph W OBG
9 Glenview Ave
Oil City PA 16301
BENNETT, MD, Peter H FP
Box 200-M Rd 3
Slippery Rock PA 16057
BLANCHARD, MD, Donovan C GS
1122 Liberty St
Franklin PA 16323
BOYER, MD, Walter E FP
9 Glenview Ave
Oil City PA 16301
BRAUNSTEIN, MD, Steven A IM
176 E Bissell Ave
Oil City PA 16301
BROWN, MD, Manson GS
1214 Elk St
Franklin PA 16323
CENEDELLA, MD, Stephen C IM
150 Prospect Ave
Franklin PA 16323
CHEN, MD, Henry Y OBG
614 E Main St
Titusville PA 16354
CORBET, MD, Roland H AN
Box 162
Polk PA 16342
CULP, MD, Robert T GPM
Oil City Hosp
Oil City PA 16301
DENLINGER, MD, Lee E IM
418 N Washington St
Titusville PA 16354
DUNN, MD, Joseph P GP
407 Third St
Titusville PA 16354
DUNN, MD, William F IM
150 Prospect Ave
Franklin PA 16323
EDWARDS, MD, William P CD
515 Gurney Rd
Franklin PA 16323
EMERSON, MD, John A OPH
312 13Th St
Franklin PA 16323
EMMOLO, MD, Alfonse A IM
122 W First St
Oil City PA 16301
ESPARRAGUERA, MD, Francisco U
9 Glenview Ave
Oil City PA 16301
FAN, MD, Young C GS
119 E Mechanic St
Titusville PA 16354
FEE JR, MD, William H IM
150 Prospect Ave
Franklin PA 16323
FETTEROLF, MD, Michael L FP
204 Nesbit Street
Franklin PA 16323
FLORES, MD, Susan G IM
12 Oakwood Dr
Oil City PA 16301
FLORES, MD, Toribio C OTO
176 E Bissell Ave
Oil City PA 16301
FRITZ, MD, William D ORS
180 East Bissell Avenue
Oil City PA 16301
GABRIELE, MD, Robert L OPH
205 West St
Oil City PA 16301
GARDNER, MD, Thomas A R
One Spruce St
Franklin PA 16323
GARDNER, MD, Thomas W OPH
401 Forest Lane
Franklin PA 16323
GARNER, MD, Lois L IM
P O Box 849
Franklin PA 16323
GENT, MD, Joseph A IM
150 Prospect Ave
Franklin PA 16323
GLOWACKI, MD, Francis L AN
Franklin Hosp
Franklin PA 16323
GOLD, MD, Arnold Z IM
122 W 1st St
Oil City PA 16301
GRIFFEN, MD, Helen S PTH
2966 Cates Circle
Port St Lucie FL 33452
GRIFFEN, MD, R Howard PTH
2966 Cates Circle
Port St Lucie FL 33452
HAJI-DJAFARI, MD, Azizeh PTH
174 E Bissell Ave
Oil City PA 16301
HAM, MD, James W OBG
150 Prospect Ave Ste 202
Franklin PA 16323
HANMER, MD, Clark B FP
P O Box 508
Emlenton PA 16373
HARTMAN, MD, Michael J ORS
125 W Walnut St
Titusville PA 16354
HEASLEY, MD, Kenneth H PD
Box 128
Tionesta PA 16353
HOLMES, MD, Robert B OBG
9 Glenview Ave
Oil City PA 16301
HOUSER, MD, James J IM
150 Prospect Ave
Franklin PA 16323
JOHNSON, MD, Robert B D
108 N 13th St
Franklin PA 16323
JOHNSTON, MD, James B P
9 Glenview Ave
Oil City PA 16301
JUPIN, MD, John A EM
Rd 3 Box 369
Franklin PA 16323
KARIAN, MD, John M NS
317 Gurney Rd
Franklin PA 16323
KEPP, MD, Edward A FP
P O Box 570
Cranberry PA 16319
KINOSIAN, MD, Mary J N
1261 Elk Street
Franklin PA 16323
KIRTLAND III, MD, Howard H ON
One Dale Ave
Franklin PA 16323
KLEIN, MD, Rolf A ORS
150 Prospect Ave
Franklin PA 16323
KLINGER, MD, Frank A CDS
150 Prospect Ave
Franklin PA 16323
KUMAR, MD, Harinath V U
32 Seneca St
Oil City PA 16301
LANDOLT, MD, Dolores M PD
9 Glenview Ave
Oil City PA 16301
LAVERDE, MD, Philip S GS
507 1/2 W Third Street
Oil City PA 16301
LIBUNAO III, MD, Jose P PD
Seven Votech Drive Apt 5C
Oil City PA 16301
MAKNOON, MD, Ali A ORS
222 Park Ave
Oil City PA 16301
MALONE, MD, William J PD
110 N 13th St
Franklin PA 16323
MARSHALL, MD, Jane M EM
R D 2
Seneca PA 16346
MASON, MD, Charles E R
One Spruce St
Franklin PA 16323
MAURER, MD, Carol N P
15 Stewart Rd
Oil City PA 16301
MCAFEE, MD, Roy D FP
P O Box 265
Clintonville PA 16372
MCCANDLESS, MD, David P IM
1228 Elk St
Franklin PA 16323
MCCANDLESS, MD, Garrett C GP
1228 Elk St
Franklin PA 16323
MCCANDLESS, MD, Warren J GP
1228 Elk St
Franklin PA 16323
MCCARTER, MD, Samuel B R
9 Somac Dr
Seneca PA 16346
MCCLELLAND JR, MD, OS
James H
1550 Pittsburgh Rd
Franklin PA 16323
MCCLUSKY, MD, Robert C OBG
150 Prospect Ave
Franklin PA 16323
MCGEHEE, MD, Daniel FP
One Spruce St
Franklin PA 16323
MCKINLEY, MD, Erin A EM
105 Woodland Dr
Oil City PA 16301
MERCED, MD, Jorge M AN
132 E Bissell Avenue
Oil City PA 16301
MILSOVIC, MD, Robert C R
Franklin Hosp
Franklin PA 16323
MOEHS, MD, Charles J FP
One Spruce St
Franklin PA 16323
MULLICK, MD, Jowheri J OBG
178 E Bissell Ave
Oil City PA 16301
NAZZARO, MD, Ralph GS
106 N Perry St
Titusville PA 16354
OCONNOR, MD, John V R
One Spruce St
Franklin PA 16323
PADALINO, MD, Michael J IM
310 13Th St
Franklin PA 16323
PADIN, MD, Frederico A U
150 Prospect Ave
Franklin PA 16323
PETERS, MD, Leonard L GS
320 16Th St
Franklin PA 16323
PHADKE, MD, Madhav V GS
28 Seneca St
Oil City PA 16301
PHADKE, MD, Usha M AN
Four Paul Revere Rd
Oil City PA 16301
PILEWSKI, MD, Robert M IM
122 W First St
Oil City PA 16301
POZZA, MD, Nicholas J GS
29 Oakwood Dr
Oil City PA 16301
RAUB, MD, Jeffrey D IM
616 Elk St
Franklin PA 16323
REAMER, MD, Donald M R
104 Woodland Dr
Oil City PA 16301
RIGHTOR, MD, John T GP
204 Central Ave
Oil City PA 16302
ROODE, MD, Albert G EM
R D 1 Box 158
Utica PA 16362
ROODE, MD, Philip J EM
440 Moreland Dr
Franklin PA 16323
ROSEN, MD, Daniel H OTO
128 W Central Ave
Titusville PA 16354
SECHLER, MD, Edith W OS
Polk Center
Polk PA 16342
SERWINT, MD, Michael S ON
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Franklin PA 16323
SHAPIRO, MD, Stuart G IM
122 W First St
Oil City PA 16301
SHIREY, MD, Pamela S FP
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Franklin PA 16323
SUK, MD, Jin H CLP
Franklin Hosp
Franklin PA 16323
THOMAS, MD, Thomas GP
30 Seneca St
Oil City PA 16301
THOMPSON, MD, Peter J IM
150 Prospect Ave
Franklin PA 16323
TIMNEY, MD, Thomas E OPH
209 E Nineth St
Oil City PA 16301
TIPTON, MD, Raymond L IM
R D 3
Titusville PA 16354
VILLANUEVA, MD, Onofre Q PD
Hamburg Center
Hamburg PA 19526
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WAGNER, MD, Louis J TS
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Franklin PA 16323
WAGNER, MD, Robert A OBG
150 Prospect Ave Ste 202
Franklin PA 16323
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180 E Bissell St
Oil City PA 16301
WRIGHT, MD, David L PD
110 N 13th St
Franklin PA 16323

WARREN

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R D 1 Werner Dr
Russel PA 16345
BALL, MD, William L OPH
124 Prescott Ln
Warren PA 16365
BERTA, MD, Julius W TR
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Warren PA 16365
BIALAS, MD, Paul A IM
103 St Clair St
Warren PA 16365
BORGER, MD, Lee J PD
R D 1 Box 1066
Russell PA 16345
BRENNAN, MD, Leonard H P
P O Box 249
Warren PA 16365
BRYAN JR, MD, Ross E FP
R D 1 7 Eaton Dr A-1365
Clarendon PA 16313
BUTT JR, MD, Frank H AN
506 S State Street
North Warren PA 16365
CARSON, MD, Thomas E GER
209 N State St
North Warren PA 16365
CASHMAN, MD, William M OS
108 W Third Ave
Warren PA 16365
CHAREPOO, MD, Khashaiar U
410 Market St
Warren PA 16365
DESHPANDE, MD, Asha S P
5311 Teakwood Ct
Erie PA 16506
ELVIR, MD, Ramon FP
211 E Main
Youngsville PA 16371
ERICSSON, MD, Francis S OBG
Two Beaty Court
Warren PA 16365
FINO, MD, Julius A OBG
308 Market Street
Warren PA 16365

FRITZ JR, MD, Karl J R
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North Warren PA 16365
FURMAN, MD, Donald J PTH
Warren Gen Hosp
Warren PA 16365
GABRESKI, MD, Robert G IM
103 St Clair St
Warren PA 16365
GRANT, MD, Alfred A FP
28 Forest St
Sugargrove PA 16350
GUPTA, MD, Sarv K P
Warren State Hospital
Warren PA 16365
GUPTA, MD, Vinodini P
Warren State Hosp
Warren PA 16365
HAUCH, MD, James F GS
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Warren PA 16365
IGNATIUS, MD, Paul F ORS
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Warren PA 16365
JOHNSON, MD, Van W ORS
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Warren PA 16365
KEVERLINE, MD, Paul O OPH
103 W St Clair St
Warren PA 16365
KUHNEN, MD, Walter H R
112 Franklin St
Warren PA 16365
LAREAU, MD, Daniel G R
Warren Gen Hosp
Warren PA 16365
LINN, MD, John L P
Warren State Hosp
Warren PA 16365
LOWE, MD, Raymond E CD
599 Quaker Rd
Warren PA 16365
MACKENZIE, MD, Charles E GS
103 St Clair St
Warren PA 16365
MANN JR, MD, William M P
Warren State Hosp
Warren PA 16365
MCCONNELL JR, MD, David M PD
145 Pleasant Dr
Warren PA 16365
MCCUNE, MD, Quay A GS
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AKBAR, MD, Mohammad M	Schuylkill
AKBARI, MD, Saeed	Bucks
AKSU, MD, Ahmet	Northampton
AL-MATEEN, MD, Cheryl S	Delaware
AL-MATEEN, MD, Kevin B	Delaware
AL-PACHACHI, MD, Jinan T	Jefferson
ALAGIRISWAMI, MD, Krishnaswami	Columbia
ALANDETE, MD, Alvaro	York
ALARCON, MD, J Edgar	Chester
ALAVIZADEH, MD, Seyed M	Philadelphia
ALBAUGH, MD, Mary A M B	Philadelphia
ALBERGO, MD, Robert P	Lancaster
ALBERICO, MD, Anthony M	Philadelphia
ALBERSTADT, MD, Norbert F	Erie
ALBERT, Barbara J	Students
ALBERT, MD, Seymour M	Philadelphia
ALBERT II, MD, John D	Erie
ALBERTINI, MD, Robert E	Montour
ALBERTS, MD, Nancy K	Beaver
ALBERTSON, MD, Richard P	Montgomery
ALBO, MD, Vincent C	Allegheny
ALBRECHT, MD, James B	Lancaster
ALBRIGHT, MD, Gerald S	Lancaster
ALBRIGHT, Janet L	Students
ALBRIGHT 3RD, MD, William J	Dauphin
ALBURGER, MD, Philip D	Philadelphia
ALCANTARA, MD, Vicente A	Washington
ALCAREZ, MD, Catherine C	Jefferson
ALCARO, MD, Joseph A	Adams
ALCARO, MD, Joseph F	Adams
ALCID, MD, Feliza A	Chester
ALCOFF, MD, Joel M	Allegheny
ALDAY, MD, Edgardo S	Philadelphia
ALDEN, MD, James C	Montgomery
ALDEN, Mark E	Students
ALDERFER, MD, Arthur J	Bucks
ALDERFER, MD, Gill R	Delaware
ALDERFER, MD, Harold H	Chester
ALDERFER, MD, Kenneth G	Delaware
ALDISERT, MD, Caesar O	Allegheny
ALDOUS, MD, Thomas W	Dauphin
ALESSI, MD, Thomas R	Montour
ALEXANDER, MD, Charles M	Delaware
ALEXANDER, MD, Fred	Philadelphia
ALEXANDER, MD, George A	Philadelphia
ALEXANDER, MD, Gilbert H	Allegheny
ALEXANDER, MD, John D	Chester
ALEXANDER, MD, Linda S	Montgomery
ALEXANDER, MD, Marcia L	Berks
ALEXANDER, MD, Maurice H	Philadelphia
ALEXANDER, MD, Michael A	Allegheny
ALEXANDER, MD, R William	Berks
ALEXANDER, MD, Raymond S	Lehigh
ALEXANDER JR, MD, John D	Philadelphia
ALEXANDERIAN, MD, Harry A	Luzerne
ALEXANDRE, MD, Journel	Montgomery
ALFALLA, Celia	Students
ALI, MD, Abu N	Westmoreland
ALI, MD, Mohammad I	Lawrence
ALIKAKOS, MD, Louis C	Delaware
ALISUAG, MD, Restituto M	Philadelphia
ALLAN, MD, David A	Philadelphia
ALLANIGUE, MD, Rogelio M	Erie
ALLCOCK, MD, Jennifer A	Philadelphia
ALLEN, MD, Chris M	Allegheny
ALLEN, MD, Dennis	Susquehanna
ALLEN, MD, Denyse M	Philadelphia
ALLEN, MD, Gregg P	Washington
ALLEN, MD, Harold Y	Franklin
ALLEN, MD, Hugh L	Erie
ALLEN, MD, John E	Jefferson
ALLEN, MD, Kevin J	Montgomery
ALLEN, MD, Lisa S	Lehigh
ALLEN, MD, Richard	Dauphin
ALLEN, MD, Robert E	Northumberland
ALLEN, MD, Robert L	Bradford
ALLEN, MD, Robert W	Mercer
ALLEN, DO, Steven K	Montgomery
ALLEN, MD, Thomas E	Allegheny
ALLEN, MD, William	Philadelphia
ALLEN JR, MD, Herbert V	Cambria
ALLEN JR, MD, Samuel D	Delaware
ALLEY, MD, Albert A	Lebanon
ALLEY, MD, Ali A	Columbia
ALLEY, MD, Richard A	Luzerne
ALLEY, MD, Samie A	Berks
ALLIEGRO, MD, George M	Montgomery
ALLISON, MD, James H	Adams
ALLISON, MD, Wesley C	Allegheny
ALLISON JR, MD, A Reid	Centre
ALLYN, MD, Russell E	Dauphin
ALMALLAH, MD, Ahmad Y	Westmoreland
ALMALLAH, MD, Shadiya	Westmoreland
ALMARIA, MD, Hermenegildo H	Luzerne
ALMASHAT, MD, Ala A	Columbia
ALMAZAN, MD, Antonio C	Lehigh
ALMQUIST, MD, John F	Erie
ALOSI, MD, Anthony J	Philadelphia
ALPERN, MD, Algernon N	Allegheny
ALPERT, MD, Barry L	Allegheny
ALPERT, MD, Charles B	Philadelphia
ALPERT, MD, Jeffrey R	York
ALPERT, MD, Richard E	Montgomery
ALSABTI, MD, Elias	Westmoreland
ALTAKER, MD, Lawrence L	Dauphin
ALTER, MD, Milton	Philadelphia
ALTHOUSE JR, MD, Lemuel B	Dauphin
ALTIMARE, MD, Peter J	Lancaster
ALTLAND, MD, Robert C	York
ALTMAN, MD, Arthur A	Northampton
ALTMAN, MD, Brian D	Montgomery
ALTMAN, MD, Cynthia B	Philadelphia
ALTMAN, DO, Fred E	Philadelphia
ALTMAN, MD, Harold A	Armstrong
ALTMAN, MD, Louis	Allegheny
ALTMAN, MD, Sidney I	Montgomery
ALTMAN, MD, Wanda	Allegheny
ALTMAN JR, MD, Richard S	Lancaster
ALTOBELLI, MD, John A	Lehigh
ALTOMARE JR, MD, Frank J	Lehigh
ALTOMONTE, MD, Joseph F	Montgomery
ALTSCHULER, MD, Stanley L	Philadelphia
ALVEAR, MD, Domingo T	Dauphin
ALVEAR, MD, Veneranda B	Dauphin
AMACHER, MD, Howard C	Erie
AMADIO, DO, Angelo E	Clarion
AMADIO, MD, Julio J	Montgomery
AMADIO JR, MD, Peter	Philadelphia
AMARO, MD, Mario	Philadelphia
AMBANI, MD, Narendra V	Carbon
AMBRAD, MD, Antonio J	Allegheny
AMBROSE, MD, C Huber	Westmoreland
AMBROSE, MD, David N	Potter
AMBROSE, MD, Julius W	Allegheny
AMBRUSO, MD, Victor T	Luzerne
AMEND, MD, Thomas C	Lancaster
AMENTA, MD, Peter S	Philadelphia
AMENTLER, MD, John P	Luzerne
AMIDON, MD, Charles S	Montgomery
AMIN, MD, Atul K	Northampton
AMIN, MD, Bipin R	Montgomery
AMINA, MD, Suresh P	Lawrence
AMMER, MD, John L	Allegheny
AMMON, MD, John R	Allegheny
AMRHEIN, MD, Regis A	Allegheny
AMROM, MD, George J	Philadelphia
AMSBAUGH, MD, Glenn A	York
AMSHEL, MD, Albert L	Allegheny
AMSLER JR, MD, Fred R	Lycoming
AMSTER, DO, Norman H	Montgomery
AMSTERDAM, MD, Gerald H	Philadelphia
AMSTERDAM, MD, Jules	Philadelphia
AMUSO, MD, Samuel J	Dauphin
ANANIA, Frank A	Allegheny
ANANTHA-RAMAN, MD, Ambale S	Allegheny
ANASTASI, MD, Joseph D	Philadelphia
ANDAL, MD, Andres H	Montgomery
ANDERKO, MD, Frank T	Lehigh
ANDERSEN, MD, Edwin	Montgomery
ANDERSEN, MD, James S	Philadelphia
ANDERSEN, MD, Thomas W	Lancaster
ANDERSON, MD, Alice M	Philadelphia
ANDERSON, MD, Arlo C	Montgomery
ANDERSON, MD, Carolyn H	Allegheny
ANDERSON, MD, Claus L	Allegheny
ANDERSON, MD, David J	Philadelphia
ANDERSON, MD, Gordon P	Erie
ANDERSON, MD, Herbert H	Allegheny
ANDERSON, MD, John B	Berks
ANDERSON, MD, John R	Northampton
ANDERSON, MD, Joseph B	Allegheny
ANDERSON, MD, Richard E	Allegheny
ANDERSON, MD, Victor S	Westmoreland
ANDERSON, MD, William C	Venango
ANDERSON, MD, William L	Allegheny
ANDERSON, MD, William M	Dauphin
ANDERSON III, MD, John D	Montgomery
ANDERSON JR, MD, Lyle F	Dauphin
ANDERSON JR, MD, William H	Erie
ANDO, MD, Teodoro A	Lycoming
ANDOLINA, MD, Stephen	Fayette
ANDRE, MD, Michel W	Bradford
ANDREOZZI, MD, Robert J	Lebanon
ANDREWS, MD, A Thomas	Dauphin
ANDREWS, MD, Gayle M	Philadelphia
ANDREWS, MD, Paul J	Luzerne
ANDREWS, MD, Percy J	Dauphin
ANDREWS, MD, Peter J	Luzerne
ANDREWS, MD, Waverly S	Philadelphia
ANDRIES, MD, Raymond C	Delaware
ANDRIES, MD, Raymond M	Montgomery
ANDRIOLA, MD, Frank J	Dauphin
ANDRIOLE, MD, Gerald L	Luzerne
ANDRIOLE, MD, Joseph P	Lackawanna
ANDRIS, DO, Joseph J	Delaware
ANDROSKI, MD, John J	Lackawanna
ANDRUCZYK, DO, Eugene	Philadelphia
ANDRZEJEWSKI JR, MD, Chester	Delaware
ANEJA, MD, Krishan K	Lackawanna
ANEJA, MD, Surinder K	Allegheny
ANGELO, MD, John J	York
ANGIULLI, Marcia	Allegheny
ANGLE, MD, William D	Lycoming
ANGSTADT JR, MD, Paul N	Montgomery
ANGULO, MD, Armand J	Franklin
ANGUS, MD, Leslie R	Montour
ANKER, MD, Peter M	Dauphin
ANNESE, DO, Joseph S	Lancaster
ANNESLEY JR, MD, William H	Delaware
ANNI, MD, Jane G O	Dauphin
ANNON JR, MD, Walter T	Philadelphia
ANO, MD, Antonio C	Philadelphia
ANOLIK, MD, Mitchell A	Philadelphia
ANSELMI, MD, Lanning A	Luzerne
ANSON, MD, Peter M	Lehigh
ANSTANDIG, MD, Jack	Allegheny
ANTALIK, MD, Paul E	Allegheny
ANTEMANN, MD, Richard W	Cambria
ANTENSON, MD, Charles M	Philadelphia
ANTHONY, MD, John A	Montgomery
ANTHONY, MD, Jonathan M	Venango
ANTHONY, MD, Mark S	Dauphin
ANTI, MD, Alvise G	Allegheny
ANTICO, MD, Dominic A	Beaver
ANTKOWIAK, MD, Thomas L	Venango
ANTOGNOLI, MD, William J	Lackawanna
ANTONCIC, MD, Rudolph A	Allegheny
ANTONIADES, MD, John	Philadelphia
ANTONUCCI, MD, Donna L	Montgomery
ANTOON, DO, Michael S	Erie
ANTOON JR, MD, Saleem J	Westmoreland
ANTOS, MD, John M	Bradford
ANTOS, MD, Michael D	Dauphin
ANTOS, MD, Thomas J	Allegheny
ANTYPAS, MD, Philip G	Allegheny
ANZALONE, MD, Angelo A	Luzerne
AOUN, MD, Kamal H	Venango
APFELBAUM, MD, Jay H	Northampton
APOSTOLIDIS, MD, Panayotis	Philadelphia
APPEL, MD, John W	Philadelphia
APPLE, Richard J	Allegheny
APPLEBAUM, Richard J	Students
APPLEGATE, MD, Mary S	Dauphin
APPLESTEIN, MD, Bruce	Bucks
APTON, MD, Jeffrey H	Allegheny
AQUILINO, MD, James F	Erie
ARANGIO, MD, George A	Lehigh
ARANO, MD, Leonardo V	Montgomery
ARASTU, MD, Mohammad I	Northampton
ARAVABHUMI, MD, Srinivas	Philadelphia
ARAVENA, MD, Ernesto B	Allegheny
ARAYA, MD, Fernando	Luzerne
ARBITMAN, MD, Michael	Beaver
ARBOGAST JR, MD, John W	Union
ARBOGAST SR, MD, John W	Union
ARCH JR, MD, Francis J	Allegheny
ARCILLA, MD, Jaime D	Bucks
ARD, MD, Robert S	Allegheny
ARDIRE, MD, Anthony J	Bradford
ARDISON, MD, Gary W	York
ARDITO, MD, Joseph M	Delaware
ARDIZONE, MD, Rohlo A	Bucks
ARENA, MD, Sebastian	Allegheny
ARENDASH-DURAND, MD, Barbara E	Philadelphia
ARENTSEN, MD, Juan J	Philadelphia
AREZA, MD, Pablo R	Fayette
ARGENIO, MD, Sandra L	Montour
ARGENTINE JR, MD, Robert P	Allegheny
ARGER, MD, Peter H	Philadelphia
ARGIRES, MD, James P	Lancaster
ARGUMEDO, MD, Victor A	Allegheny
ARGYROS, Gregory J	Allegheny
ARKLESS, MD, Henry A	Philadelphia
ARMANIOUS, MD, Adel W	Westmoreland
ARMAO, MD, Joseph J	Delaware
ARMEN, MD, Robert N	Allegheny
ARMENTO, MD, Donald F	Philadelphia
ARMFIELD III, MD, Samuel L	Allegheny
ARMITAGE, MD, Harry V	Delaware
ARMOUR, MD, William S	Philadelphia
ARMSTRONG, MD, B Irene	Elk/Cameron
ARMSTRONG, MD, Schuyler S	Delaware
ARMSTRONG, MD, Thomas A	Montgomery
ARMSTRONG, MD, Thomas S	Cumberland
ARNAO, MD, James	Philadelphia
ARNDT, MD, Isabelle O	Montgomery
ARNDT, MD, James L	Berks
ARNER, MD, Raymond H	Northampton
ARNETT, MD, John H	Philadelphia
ARNHEIM, MD, Falk K	Allegheny
ARNO, MD, Irvin C	Philadelphia
ARNO, MD, J Thomas	Crawford
ARNOLD, MD, George L	Allegheny
ARNOLD, MD, John J	Clearfield
ARNOLD, Laura S	Allegheny
AROMATORIO, MD, George J	Allegheny
ARONICA, MD, Michael J	Lackawanna
ARONSON, MD, Jerold M	Philadelphia
ARONSON, MD, Kenneth S	Allegheny
ARONSON, MD, Morton L	Allegheny
ARONSON, MD, Susan S	Philadelphia
ARONSTAM, MD, Robert H	Bradford
ARORA, MD, Ramesh	Cumberland
ARORA, MD, Sat P	Delaware
ARORA, MD, Subhash C	Lackawanna
AROUH, MD, Albert	Delaware
ARSHT, MD, Edwin D	Delaware
ARTABANE, MD, Thomas A	Lackawanna
ARTHUR, MD, Rodney S	Dauphin
ARTIS, MD, Cathy J	Allegheny
ARTYMYSHYN, MD, H Renee L	Philadelphia
ARUMUGARAJAH, MD, Kanagasabapath	Adams

ASBELL, MD, Sucha O	Philadelphia
ASCANIO, MD, Guido	Delaware
ASEEM, MD, Wali M	Jefferson
ASH, MD, Russell R	Montgomery
ASHBAUGH, MD, William H	Butler
ASHBY, MD, John D	Franklin
ASHIZAWA, MD, James H	Berks
ASHMAN, MD, George S	Cambria
ASHOK, MD, Puducheri S	Allegheny
ASHWORTH, MD, Halbert E	Berks
ASKAR, MD, F	Philadelphia
ASKIN, MD, Ralph J	Allegheny
ASKIN, MD, Stanley R	Centre
ASKINAS, MD, Alan M	Chester
ASLAM, MD, Azar	Crawford
ASLAM, MD, Mohammad	Schuylkill
ASNANI, MD, Mithlesh G	Lehigh
ASO, MD, Orlando A	Carbon
ASPEN, MD, Nelson P	Chester
ASSANASEN, MD, Benja V	Westmoreland
ASSANASEN, MD, Charin	Westmoreland
ASSAR, MD, Suda P	Cambria
ATHANI, MD, Vijay S	Allegheny
ATKIN, MD, David H	Allegheny
ATKINS, MD, John L	York
ATKINS JR, MD, Joseph P	Philadelphia
ATKINSON, MD, Nolan N	Montgomery
ATKINSON, MD, Whittier C	Chester
ATLEE, MD, William A	Lancaster
ATRI, MD, Srinivas S	Bucks
ATTEWELL, MD, Joseph V	Philadelphia
ATWELL, DO, Grant E	Somerset
ATWELL, MD, Robert B	Allegheny
ATWELL II, DO, Grant E	Somerset
AU, MD, Francis C	Philadelphia
AU, MD, Victor K	Dauphin
AUCH, MD, Ella M	Northampton
AUDAY, MD, Jose H	Philadelphia
AUERBACH, MD, Herman L	Luzerne
AUERBACH, MD, Mark H	Northampton
AUERBACH, DO, Robert S	Philadelphia
AUGELLI-HODOR, DO, Linda P	Northampton
AUGHINBAUGH, MD, Thomas H	Clearfield
AUGSBURGER, MD, James J	Philadelphia
AURAND, MD, Eleanor M	Mifflin/Juniata
AURANDT, MD, Henry N	Berks
AURE, MD, Horacio S	Allegheny
AURE, MD, Isabel R	Allegheny
AUSLANDER, MD, James L	Allegheny
AUSTIN, MD, Charles B	Beaver
AUSTIN, MD, Edward M	Allegheny
AUSTIN, MD, George L	Westmoreland
AUSTRIAN, MD, Robert C	Philadelphia
AVANCENA, MD, Edgardo P	Montgomery
AVELLA, MD, Bernard N	Berks
AVELLINO, MD, Joseph D	Philadelphia
AVENIA, MD, Ronald J	Columbia
AVERSA, MD, Nicholas	Philadelphia
AVERSA JR, MD, Zefferino A	Philadelphia
AVNER, MD, David L	Greene
AWAD, MD, Latif L	Montour
AWAN, MD, Ihsan-Ul H	Allegheny
AWAN, MD, Rashid A	Cambria
AXELROD, MD, Budd B	Philadelphia
AXELROD, DO, Norman M	Lancaster
AXELROD, MD, Rita S	Philadelphia
AXELSON, MD, Alan A	Allegheny
AXLINE, David R	Allegheny
AYE, MD, J Thomas	Mercer
AYERLE, MD, Robert S	Philadelphia
AYERS, MD, Lloyd R	Blair
AYERS JR, MD, William H	Delaware
AYLWARD, MD, John J	Chester
AYNARDI, MD, J Marc	Berks
AYOUB, MD, William T	Mifflin/Juniata
AYRES, MD, John A	Blair
AYRES, MD, John R	Montour
AYRES, MD, William W	Fayette
AYULO, MD, Marco A	Mercer
AZAR, MD, Albert A	York
AZAR, MD, Reza R	Philadelphia
AZCONA, MD, Oscar C	Washington
AZER, MD, Magdi S	Cambria
AZIMI, MD, Jaleh	Philadelphia
AZIZ, MD, Abdulrab	Allegheny
AZIZKHAN, MD, Reza G	Dauphin

B

BAADE, MD, Ernest A	Mifflin/Juniata
BABACZ, MD, Teofil	Chester
BABCOCK, MD, John R	Centre
BABIN, MD, Roman A	Elk/Cameron
BABU, MD, Vallabhaneni S	Washington
BACAK, MD, Joseph F	Northampton
BACASTOW, MD, Merle S	York
BACESKI, MD, Deborah A	Somerset
BACH, MD, William G	Beaver
BACHARACH, MD, Benjamin	Philadelphia
BACHMAN, MD, William H	Lancaster
BACHMANN, MD, Lawrence C	Allegheny
BACKENSTOSE, MD, Daniel L	Dauphin
BACKES, MD, Celso L	Potter
BACON, MD, Richard W	Lancaster
BADAWI, MD, Radwan A	Lackawanna
BADAWY, Samy B	Students
BADELLINO, MD, Michael M	Philadelphia
BADIALI, MD, S Charles	Washington
BADOLATO, MD, David J	Montgomery
BAER, MD, David G	Indiana
BAER, MD, Samuel	Philadelphia
BAERTL, MD, Juan M	York
BAEZ, MD, Raymond C	Allegheny
BAGHAI-NAIINI, MD, Parviz	Allegheny
BAHL, MD, Mohinder M	Allegheny
BAHL, MD, Vijay K	Allegheny
BAHLER, Eileen	Students
BAHNMILLER, MD, Edwin C	Luzerne
BAIL, MD, Harry	Philadelphia
BAILEY, MD, Nelson J	Mercer
BAILEY, MD, Stephen R	Allegheny
BAILEY, MD, William R	Allegheny
BAILEY III, DO, John H	Crawford
BAILEY JR, MD, John H	Crawford
BAILEY JR, MD, Robert S	Montgomery
BAILY, MD, Robert G	Dauphin
BAIR, MD, Charles W	Lancaster
BAIR, MD, Edward H	Dauphin
BAIR, MD, Jeffrey F	Monroe
BAIR, MD, Robert C	Tioga
BAIR, MD, Victor W	Washington
BAIR, MD, William L	Allegheny
BAIRD, MD, Edward F	Lancaster
BAIRD, MD, James W	Allegheny
BAIRD, MD, Robert J	Lancaster
BAIRD, MD, Robert M	Monroe
BAISAS, MD, Roger C	Bucks
BAJAJ, MD, Rajiv K	Lackawanna
BAJINA, MD, Sham R	Philadelphia
BAJOREK, MD, Edward J	Erie
BAJWA, MD, Jagdeep K	Westmoreland
BAJWA, MD, Surinder S	Westmoreland
BAKER, MD, Arthur G	Delaware
BAKER, MD, Carol C	Allegheny
BAKER, MD, Everett M	Allegheny
BAKER, MD, Graeme C	Erie
BAKER, MD, Howard W	Philadelphia
BAKER, MD, Jeffrey H	Montour
BAKER, MD, Kenneth M	Montour
BAKER, Kyle A	Allegheny
BAKER, MD, Linda J	Philadelphia
BAKER, MD, Marvin P	Butler
BAKER, Mary-Theresa	Students
BAKER, MD, Robert H	Mercer
BAKER, MD, Robert L	Allegheny
BAKER, MD, Roy F	Centre
BAKER, MD, Stephen D	Allegheny
BAKER, MD, Thomas E	Luzerne
BAKER, MD, Walter J	Allegheny
BAKER JR, MD, Arthur G	Delaware
BAKER JR, MD, George W	Franklin
BAKEWELL, MD, Frank S	Washington
BAKKEN, MD, William W	Lancaster
BAKSHI, MD, Kalind R	Philadelphia
BAKSHI, MD, Kinnari K	Bucks
BALABAN, MD, Donald J	Philadelphia
BALAKHANE, Guiti	Students
BALARAMAN, MD, Govindachetty	Franklin
BALASH, MD, William R	Armstrong
BALASUBRAMANIAN, MD, Easwaran	Philadelphia
BALCHANDANI, MD, Rajkumari B	Philadelphia
BALCITA, MD, Arthur L	Westmoreland
BALCITA JR, MD, Angel B	Westmoreland
BALDERACH, MD, Ronald R	Lawrence
BALDERSTON, MD, Richard A	Philadelphia
BALDIA, MD, Liveo B	Columbia
BALDINO, MD, William A	Lackawanna
BALDWIN, MD, Thomas M	Beaver
BALES, MD, Charles R	Erie
BALIKIAN, MD, Manuel	Lancaster
BALIN, MD, Arthur K	Delaware
BALIN, MD, Benjamin R	Delaware
BALIN, MD, Solomon L	Philadelphia
BALING, MD, Larry E	Mercer
BALIS, MD, Sol	Delaware
BALISTOCKY, MD, Marvin H	Montgomery
BALK, MD, Phillip	Allegheny
BALKANY, MD, Andrew F	Dauphin
BALKANY, MD, Christopher K	Lancaster
BALL, MD, William L	Warren
BALLANTINE, MD, Thomas V N	Dauphin
BALLANTYNE, MD, James V	Allegheny
BALLEK, MD, Ronald E	Philadelphia
BALLENTINE, MD, George N	Lycoming
BALLENTINE, MD, Rudolph M	Wayne/Pike
BALLS, MD, Kent F	Montgomery
BALMASEDA, MD, Ofelia B	Philadelphia
BALMASEDA, MD, Philip F	Philadelphia
BALOGH JR, MD, Robert J	Philadelphia
BALSAMO, MD, Anthony J	Philadelphia
BALSARA, MD, Rohinton K	Philadelphia
BALSBAUGH, MD, George T	Dauphin
BALSHI, MD, Stephen F	Northampton
BALTZ, MD, Richard D	Dauphin
BALTZELL, MD, William H	Philadelphia
BAMBERGER, MD, Grant W	Chester
BAMBERGER, MD, John A	Lebanon
BAMONT, MD, Anthony J	Philadelphia
BAMONTE, MD, Edward L	Allegheny
BANACH, MD, Stanley F	Lehigh
BANCOFF, MD, Carl	Philadelphia
BANCROFT, MD, Edith D	Montgomery
BAND, MD, Philip T	Philadelphia
BANDARANAYAKE, MD, Nisantha M	Westmoreland
BANDINI JR, MD, Paul J	Philadelphia
BANE, MD, Denis M	Schuylkill
BANERJI, MD, Barun	Luzerne
BANERJI, MD, Sipra	Luzerne
BANEY JR, MD, Charles M	Berks
BANK, MD, Arnold A	Philadelphia
BANK, MD, R Stanley	Dauphin
BANKA, MD, Reena S	Philadelphia
BANKACI, MD, Murat	Westmoreland
BANKES, MD, Terrylyn F	Allegheny
BANMILLER, MD, James D	Montgomery
BANNER, MD, Marc P	Philadelphia
BANNER, MD, Ronald S	Philadelphia
BANNETT, MD, Aaron D	Philadelphia
BANNISTER JR, MD, William B	Lawrence
BANNON, MD, Charles J	Lackawanna
BANOGON, MD, Marietta A	Dauphin
BANSAL, MD, Harinder K	Philadelphia
BANSBACH, MD, Jean M	Philadelphia
BANSBACH, MD, William A	Philadelphia
BANSIDHAR, MD, Bhadrasine	Beaver
BANTLEY JR, MD, David S	Philadelphia
BANTLY, MD, Harry C	Jefferson
BANTLY, MD, Victor S	Cambria
BANZHOFF, MD, Gordon K	Dauphin
BAQUERO, MD, Ashley	Philadelphia
BAQUERO-BUENO, MD, Mario R	Washington
BAR, MD, Allen H	Philadelphia
BARAFF, MD, Robert	Allegheny
BARAKAT, MD, Adel R	Lackawanna
BARAN, MD, Ernest M	Montgomery
BARANOWSKI, Robert J	Students
BARANSKI, MD, Edward J	Adams
BARBER, MD, John V	Westmoreland
BARBER, MD, Lee A	Philadelphia
BARBER, MD, Margaret	Philadelphia
BARBIERI, MD, Edward A	Philadelphia
BARBO, MD, Dorothy M	Philadelphia
BARBOUR, MD, Peter J	Lehigh
BARCLAY, MD, Clayton C	Schuylkill
BARCLAY, MD, William A	Indiana
BARCLAY JR, MD, Clayton C	Montgomery
BARD, MD, Joseph L	Montgomery
BARDONNER, MD, John N	Allegheny
BARDZIL, MD, Joseph W	Washington
BARENBAUM, MD, Daniel H	Philadelphia
BARENBERG, MD, Paul A	Chester
BARG, MD, Ronald B	Montgomery
BARILLA, MD, Donald E	Lehigh
BARKER, MD, Clyde F	Philadelphia
BARKER, MD, Richard G	Philadelphia
BARLEY, MD, Samuel B	Jefferson
BARLOW, MD, Anne L	Montgomery
BARMADA, MD, Bicher	Allegheny
BARNA, Nicholas J	Students
BARNABY JR, MD, Arthur J	Philadelphia
BARNES, MD, Anne U	Philadelphia
BARNES, MD, Barbara E	Venango
BARNES, MD, Ben C	Lehigh
BARNES, MD, Robert F	Blair
BARNES, MD, W Stephen	Centre
BARNES, MD, William J	Allegheny
BARNES, MD, William T	Centre
BARNES, MD, Willis C	Lackawanna
BARNES II, MD, Arthur E	Westmoreland
BARNETT, MD, Alan J	Allegheny
BARNETT, MD, E Michael	Allegheny
BARNETT, MD, Marian	Clarion
BARNETT, MD, Ronald B	Philadelphia
BARNHART, MD, Arthur D	Westmoreland
BARNHOUSE, MD, David H	Allegheny
BARNOSKI, MD, John F	Dauphin
BARON, MD, Arthur M	Montgomery
BARON, MD, John	Allegheny
BARON, MD, Maxine E	Allegheny
BARON, MD, Raymond C	Philadelphia
BARON, MD, Scott L	Allegheny
BARON JR, MD, Andrew J	Lackawanna
BARONE, MD, Anthony	Lehigh
BARONE, MD, Samuel F	Allegheny
BARR, MD, Gary A	Allegheny
BARR, MD, Harry J	Delaware
BARR, MD, Richard G	Delaware
BARR, MD, Samuel S	Philadelphia
BARR, MD, V Ward	Lancaster
BARR, MD, William B	Lehigh
BARR JR, MD, James H	Allegheny
BARRAS, MD, David I	Luzerne
BARRER, MD, Mitchell J	Bucks
BARRER, MD, Steven J	Philadelphia
BARRERA, MD, Anthony M	Allegheny
BARRETT, MD, George S	Northampton
BARRETT, MD, John S	Berks
BARRETT, MD, Judith N	Lehigh
BARRETT, MD, Michael J	Philadelphia
BARRETT, MD, Stephen J	Lehigh
BARRETT, MD, William A	Allegheny
BARRINGER, MD, Lydia R	Philadelphia
BARRIOS, MD, Antonio	Philadelphia
BARRIOS, MD, Mario F	Berks
BARRIS, MD, Bruce J	Bucks
BARRIST, MD, Ellis M	Philadelphia
BARRON, MD, Kenneth G	Allegheny
BARRY, MD, William E	Philadelphia
BARRY, MD, William J	Chester
BARSANTI, MD, Ronald G	Dauphin
BARSOUM, MD, Adib H	Westmoreland
BARTGES, MD, John D	Lancaster
BARTH, MD, Maury C	Allegheny
BARTHO, MD, Blaine F	Perry
BARTHOLOMEW, MD, William W	Greene
BARTLE JR, MD, Harvey	Montgomery
BARTLETT, MD, Glen S	Dauphin
BARTLETT JR, MD, Frederick H	Montgomery
BARTO, MD, Jack W	Cambria
BARTOLET, MD, Terry L	Northampton
BARTON, MD, Diane	Philadelphia
BARTON, MD, F Jane	Dauphin
BARTON, MD, James C	Franklin
BARTON, MD, Mary C	Dauphin
BARTON, MD, Robert L	Lebanon
BARTOS, MD, Joseph E	Northampton
BARTOS, MD, Sylvia A	Washington
BARTOSIK, MD, Delphine B	Philadelphia
BARTUSIS, MD, Mary A	Bucks
BARTUSKA, MD, Doris G	Philadelphia
BARUA, MD, Subrata P	Westmoreland
BARUSEWYCZ, MD, Sr Maria N	Philadelphia
BARZYK, MD, Peter P	Erie
BASAK, MD, Bijan K	Potter
BASARAB, MD, Robert M	Dauphin
BASEMAN, DO, Donald A	Montgomery
BASHARA, MD, Thomas J	Lawrence
BASHLINE, DO, Bruce S	Dauphin
BASHLINE, MD, Don L	Mercer
BASHLINE, MD, H Woodrow	Mercer
BASHOR, DO, Steven B	Philadelphia
BASHORE JR, MD, Robert M	Lancaster
BASILE, MD, Joseph	Blair
BASKA, MD, John K	Beaver
BASKIN, MD, Andrew J	Chester
BASOM, MD, Donald E	Mifflin/Juniata
BASS, MD, Eric B	Allegheny
BASSALY, MD, Rifaat R	Lawrence
BASSERT, MD, David E	Bucks
BASSETT, MD, James G	Philadelphia
BASSETTI, MD, Dennis R	Mifflin/Juniata
BASSILIOS, MD, Fouad A	Allegheny
BAST, MD, William R	Adams
BASTIAN, MD, Grace A	Philadelphia
BASTIAN, MD, James R	Lycoming
BATAILLE, MD, Jacques A	Mercer
BATCHELET, DO, Richard B	Delaware
BATES, MD, James S	Montour
BATES, MD, Mark A	Dauphin
BATES JR, MD, Ollice	Montour
BATHON II, MD, G Howard	Fayette
BATHRICK, MD, Charles E	Erie
BATIPPS JR, MD, Percy O	Delaware
BATLUCK, DO, David J	Lackawanna
BATOFF, MD, Milton A	Philadelphia
BATORY, MD, Katherine H	Centre
BATRA, MD, Preet M	Philadelphia
BATTAFARANO, MD, Leonard A	Philadelphia
BATTAFARANO, MD, Nicholas C	Chester
BATTERTON, MD, Thomas D	Philadelphia
BATTISTA, MD, Frank J	Dauphin
BATTISTA, Michael A	Students
BATTISTINI, MD, Michelle M	Philadelphia
BATTS JR, MD, James A	Philadelphia
BATZER, MD, Frances R	Philadelphia
BAUDER, MD, Elizabeth S	Lehigh
BAUER, MD, Frank L	Allegheny
BAUER, MD, James E	Armstrong
BAUER, MD, John A	Armstrong
BAUER, MD, Robert L	Lebanon
BAUER, MD, Thomas L	York
BAUER, MD, William F	Allegheny
BAUERSFELD, MD, S Richard	Allegheny
BAUGH, MD, Wilfreta G	Philadelphia
BAUM, MD, Edgar S	Lehigh
BAUM, MD, Neil B	Venango
BAUM, MD, Sheldon	Delaware
BAUM, MD, Stanley	Philadelphia
BAUM-BARVIE, MD, Alicia	Westmoreland
BAUMAN, MD, Dorothy H	Allegheny
BAUMAN, MD, Thomas W	Lawrence
BAUMANN, MD, Brenda K	Clearfield
BAUMANN, MD, Thomas L	Clearfield
BAUMGARTEL, MD, Ira E	Allegheny
BAUSCH, MD, Andrew N	Philadelphia
BAUSCH, MD, Richard D	Lehigh
BAUSCH JR, MD, Frederick R	Lehigh
BAUTISTA, MD, Primo V	Westmoreland
BAUZON, MD, Narciso C	Schuylkill
BAVARIA, MD, Joseph E	Philadelphia
BAVER, MD, George A	Montgomery
BAXT, MD, Leon	Philadelphia
BAXTER, MD, John A	Montour
BAYANI JR, MD, Eladio Y	Westmoreland
BAYER, DO, Jay D	Franklin
BAYER, MD, Joseph F	Washington
BAYNE, MD, Gilbert M	Philadelphia
BAYRI, MD, Mehmet F	Lehigh
BAYUK, MD, John D	Mercer
BAZMI, MD, Hassan	Allegheny
BAZRON, MD, Herbert	Allegheny
BAZYLAK, MD, Robert A	Crawford
BAZZOUI, MD, Widad	Mckean
BEACHER JR, MD, George W	Lancaster
BEACHLER, MD, John S	Allegheny
BEACHY, MD, Ivan E	Cumberland
BEACHY, MD, Stanley C	Cumberland
BEALE, MD, Benjamin R	Dauphin
BEALER, MD, John D	Northampton
BEALS, MD, Norman K	Venango
BEAM, DO, Walter D	Westmoreland
BEAN, MD, Carl B	Butler

BEANE, MD, Howard C	Dauphin
BEARDWOOD, MD, Donald M	Montgomery
BEATTY, MD, Albert C	Philadelphia
BEATTY, MD, Ralph P	Allegheny
BEAUCHAMP JR, MD, Eugene W	Philadelphia
BEAUGARD, MD, Mark E	Chester
BEAUSANG, MD, Thomas	Schuylkill
BEAVER, MD, Warren J	Erie
BECER, MD, Mark E	Montgomery
BECK, MD, Aaron T	Philadelphia
BECK, MD, Allan G	Philadelphia
BECK, MD, Bonny L	Montour
BECK, MD, Christine H	Northampton
BECK, MD, Donald E	Mercer
BECK, MD, Gerald	Erie
BECK, MD, Gunhilde M	Dauphin
BECK, MD, Jan	Bradford
BECK, DO, Jonathan E	Montgomery
BECK, MD, Robert H	Huntingdon
BECK, MD, Ronald C	Allegheny
BECK, MD, Sidney	Philadelphia
BECK, MD, William C	Bradford
BECK JR, MD, William C	Montgomery
BECK JR, MD, William W	Philadelphia
BECKER, MD, Bruce	Columbia
BECKER, MD, Carl K	Lebanon
BECKER, MD, David J	Philadelphia
BECKER, MD, Hilary J	Lancaster
BECKER, MD, Irwin	Philadelphia
BECKER, MD, Joseph M	Philadelphia
BECKER, MD, Keith R	Montour
BECKER, Lynne E	Students
BECKER, MD, Martin S	Northampton
BECKER, MD, Stephen E	Blair
BECKER, MD, Ward G	Berks
BECKLEY, MD, Robert F	Lycoming
BECKMAN, Evan M	Students
BECKMAN, DO, Irwin	Allegheny
BECKMAN, MD, William R	Adams
BECKWITH, MD, William R	Delaware
BEDDINGS, MD, Alejandro	Philadelphia
BEDELL, MD, Alan N	Allegheny
BEDFORD, MD, Richard A	Philadelphia
BEDGER JR, MD, Richard C	Allegheny
BEDNAREK, MD, Joseph M	Philadelphia
BEDNAREK, MD, Thomas F	Bradford
BEDNARSKI, MD, Jeffrey J	Erie
BEDNARZ, MD, Wallace W	Lycoming
BEDRICK, MD, Edward L	Philadelphia
BEDROSSIAN, MD, E Howard	Delaware
BEDROSSIAN, MD, Edward H Jr	Delaware
BEE, MD, Daniel H	Indiana
BEEBY, MD, James L	Erie
BEECHAM, MD, Clayton T	Montour
BEEKEY JR, MD, Cyrus E	York
BEEKLEY, MD, William H	Chester
BEEM, MD, John W	Berks
BEERMAN, MD, Curtis A	Cambria
BEERMAN, MD, Herman	Philadelphia
BEERS, MD, Kenneth L	Blair
BEETEL, MD, Christopher J	Berks
BEG, MD, Mirza M	Philadelphia
BEGG, MD, Frank R	Allegheny
BEGUM, MD, Dilwara	Allegheny
BEH, MD, Walter P	Mercer
BEHAR, MD, Robert D	Philadelphia
BEHAR, MD, Solomon	Philadelphia
BEHBEHANIAN, MD, Mahin D	Delaware
BEHJAT, MD, Fa-Ezeh	Philadelphia
BEHR, Edith D	Students
BEHREND, MD, Bernard	Philadelphia
BEHRENDT, MD, Richard P	Mercer
BEHUN, MD, Joseph M	Allegheny
BEIDLER, MD, Jon G	Franklin
BEILER, MD, David D	Montour
BEITEL JR, MD, Robert J	Lehigh
BEITTEL, MD, James P	Lancaster
BEITTEL JR, MD, Charles R	Dauphin
BEITZEL, MD, James E	Dauphin
BEIZER, MD, Lawrence H	Philadelphia
BEKOE, MD, Seth	Allegheny
BELASCO, MD, Robert N	Montgomery
BELICH, MD, Stephen C	Beaver
BELIS, MD, Theodore E	Blair
BELJAN, MD, John R	Philadelphia
BELK, MD, H Dean	Allegheny
BELL, MD, Ella C	Philadelphia
BELL, MD, Gerald	Chester
BELL, MD, H Craig	Montgomery
BELL, MD, Harry J	Philadelphia
BELL, MD, James B	Delaware
BELL, James E	Students
BELL, MD, John C	Montgomery
BELL, MD, Lawrence D	Beaver
BELL, MD, Louis D	Philadelphia
BELL, MD, Michael C	Beaver
BELL, MD, Randall W	Delaware
BELL, MD, Richard T	Berks
BELL, MD, Robert L	Chester
BELL, MD, Thomas G	Clearfield
BELL JR, MD, C Ray	Lebanon
BELL JR, MD, David M	Washington
BELL JR, MD, Ernest A	Delaware
BELL JR, DO, Joseph W	Venango
BELLA, MD, Paraluman	Butler
BELLA, MD, Romeo H	Lawrence
BELLARMINO, MD, Francis M	Philadelphia
BELLER, MD, Martin L	Philadelphia
BELLES, MD, Terry A	Lycoming
BELLINGER, MD, Edward L	Tioga
BELLINGER, MD, Mark F	Dauphin
BELLIS, MD, John A	Chester
BELLUS, MD, John J	Montgomery
BELMONT, MD, Frank A	Perry
BELMONT, MD, Herman S	Philadelphia
BELMONT, MD, Jonathan B	Montgomery
BELMONT, MD, Owen	Philadelphia
BELSER, MD, Paul H	Philadelphia
BELTZ, MD, William R	Lycoming
BEMILLER, MD, Carl	Schuylkill
BENACK, MD, Andrea	Philadelphia
BENACK, MD, Carl A	Allegheny
BENCIE, MD, David J	Cambria
BENDER, MD, Barry L	Clinton
BENDER, MD, Bruce L	Westmoreland
BENDER, MD, George E	Bradford
BENDER, MD, Helene L	Allegheny
BENDER, MD, Joseph	Montgomery
BENDER, MD, Richard J	Allegheny
BENDER, MD, Robert R	Lancaster
BENDER, MD, William A	Franklin
BENDER JR, MD, Frank C	Delaware
BENDERSKY, MD, Gordon	Philadelphia
BENDITT, MD, Philip L	Philadelphia
BENDLIN, MD, Arnaldo	Philadelphia
BENE, MD, Catherine H	York
BENENSON, MD, Ronald S	York
BENINATI, MD, Daniel D	Chester
BENITEZ, MD, Francisco W	Blair
BENJAMIN, MD, David R	Erie
BENJAMIN, MD, Joseph	Philadelphia
BENJAMIN, MD, Kenneth W	Philadelphia
BENJAMIN, MD, Mark	Philadelphia
BENKINNEY, James A	Students
BENKO, MD, Stephen T	Cambria
BENKOVIC, MD, Gregory W	Montour
BENNER, MD, John N	Wyoming
BENNER, Robert R	Allegheny
BENNER IV, MD, John H	Chester
BENNETT, MD, Edward V	Bradford
BENNETT, MD, John L	Cambria
BENNETT, MD, John T	Montgomery
BENNETT, MD, May H	Allegheny
BENNETT, MD, Peter H	Venango
BENNETT, MD, Raymond L	Susquehanna
BENNETT IV, MD, Joseph S	Montgomery
BENNICK, MD, Michael C	Philadelphia
BENNIGHOF, MD, David C	Beaver
BENOIT, MD, Charles H	Montour
BENOIT, DO, Richard A	Delaware
BENOVITZ, MD, Burton S	Luzerne
BENSHOFF, MD, Arthur M	Cambria
BENSON, MD, Bernard E	Philadelphia
BENSON, MD, David R	Centre
BENSON, MD, Jacob M	Philadelphia
BENSON, MD, John R	Philadelphia
BENSON, Randall R	Students
BENSON, MD, William E	Philadelphia
BENSY, MD, Joseph J	Allegheny
BENSY, MD, Oliver R	Allegheny
BENT III, MD, George	Allegheny
BENTIVOGLIO, MD, Lamberto G	Philadelphia
BENTLEY, MD, Eugene A	Chester
BENTON, MD, Owen D	Washington
BENTZ, MD, Charles R	Mckean
BENTZ, MD, Michael L	Philadelphia
BENTZ, MD, Michael S	Dauphin
BENTZ, MD, Ralph A	Dauphin
BENTZ, DO, William J	Allegheny
BENZ, MD, Edward J	Northampton
BENZ, MD, Robert L	Montgomery
BENZ JR, MD, George H	Allegheny
BENZEL, MD, Stanley	Lehigh
BEPLER, MD, Charles R	Delaware
BERARDI, MD, Ronald S	Westmoreland
BERARDIS, MD, John M	Lackawanna
BERARDIS, MD, Velio E	Lackawanna
BERBERICH, MD, Walter F	Westmoreland
BERD, MD, Irvin B	Delaware
BERENBAUM, MD, Arthur A	Philadelphia
BERENBAUM, MD, Paul L	Philadelphia
BERENHOLZ, MD, Leonard P	Philadelphia
BERES, MD, Joseph C	Philadelphia
BERESKY, MD, Barnabas S	Erie
BERESNY, MD, Gerald M	Centre
BERG, MD, Alan P	Montgomery
BERG, MD, George	Allegheny
BERG, MD, Morton D	Philadelphia
BERG, MD, Philip	Philadelphia
BERG, MD, Saul R	Allegheny
BERGELSON, MD, Victor D	Montgomery
BERGER, MD, Alan	Lehigh
BERGER, MD, Alan S	Philadelphia
BERGER, MD, Bruce C	Philadelphia
BERGER, DO, Gary G	Philadelphia
BERGER, MD, Gary W	Lycoming
BERGER, MD, Jay B	Northampton
BERGER, MD, Karl	Cambria
BERGER, MD, Malcolm P	Allegheny
BERGER, MD, Mark	Dauphin
BERGER, MD, Norman S	Lackawanna
BERGER, MD, Winfried W	Huntingdon
BERGHAUS, MD, Lydia F	York
BERGHER, MD, Moises	Philadelphia
BERGMAN, MD, Martin J	Philadelphia
BERGNES, MD, Manuel A	Montgomery
BERGQUIST, MD, Erick J	Philadelphia
BERING, MD, Joseph P	Lebanon
BERING, MD, Thomas G	Lancaster
BERK, MD, David A	Allegheny
BERK, MD, Henry M	Montgomery
BERK, Lawrence B	Allegheny
BERK, MD, Myles M	Allegheny
BERK, MD, Nathaniel G	Philadelphia
BERK, MD, Steven L	Bucks
BERKEBILE, MD, Paul E	Allegheny
BERKEY, MD, Richard L	Allegheny
BERKHEIMER, MD, George A	Dauphin
BERKHEIMER, MD, Park	Dauphin
BERKHEISER, MD, Samuel W	Dauphin
BERKMAN, MD, Eugene F	Beaver
BERKMAN, MD, Ronald O	Allegheny
BERKOW, MD, Robert	Montgomery
BERKOWITZ, MD, Fred	Allegheny
BERKOWITZ, MD, Henry D	Philadelphia
BERKOWITZ, MD, Morton I	Allegheny
BERKOWITZ, MD, Peter J	Allegheny
BERKOWITZ, MD, Robert P	Philadelphia
BERLEY, MD, Benjamin S	Luzerne
BERLIN, MD, Charles S	Allegheny
BERLIN JR, MD, Cheston M	Dauphin
BERMAN, MD, Arnold M	Berks
BERMAN, MD, Arnold T	Philadelphia
BERMAN, MD, Eli	Monroe
BERMAN, MD, Howard J	Westmoreland
BERMAN, MD, Ira J	York
BERMAN, MD, Jacob H	Philadelphia
BERMAN, Scott S	Students
BERMUDEZ, MD, Armand J	Mercer
BERNABEI, MD, Joanne Y	Delaware
BERNARDINO, MD, Evelina A	Bucks
BERNARDINO JR, MD, Vitaliano B	Bucks
BERNATH JR, MD, Albert M	Montour
BERNBERG, MD, Lawrence	Chester
BERNETT, MD, Gary B	Delaware
BERNETT, MD, Timothy M	Erie
BERNHARD, MD, John J	Lehigh
BERNHARD, MD, Robert A	Lancaster
BERNS, MD, Leon L	Philadelphia
BERNSTEIN, MD, A Alexander	Lackawanna
BERNSTEIN, MD, Edward D	Allegheny
BERNSTEIN, MD, Mark H	Bucks
BERNSTEIN, MD, Richard J	Allegheny
BERNSTEIN, MD, Robert	Union
BERNSTEIN, Robert J	Students
BERNSTINE, MD, Earl L	York
BERNSTINE, MD, J Bernard	Philadelphia
BERONILLA JR, SMD, Hilarion A	Fayette
BERRETTA, Debra A	Students
BERRY, MD, George J	Allegheny
BERSCHLING, MD, Chester M	Allegheny
BERTA, MD, Julius W	Warren
BERTOLET, MD, Charles B	Berks
BERTOLETTE, MD, Richard D	Berks
BERTOLINO, MD, John G	Westmoreland
BERTRAM, MD, Horst N	Lebanon
BERTRAND, Bruce K	Allegheny
BERTSCH, MD, Albert M	Susquehanna
BERWICK, MD, Evelyn Sue	Allegheny
BERWISH, MD, Neil J	Philadelphia
BESARAB, MD, Anatole	Philadelphia
BESECKER, MD, Joseph A	Lancaster
BESEN, MD, Andrew D	Philadelphia
BESSELMAN, MD, David M	Dauphin
BESSER, MD, Joseph P	Philadelphia
BEST, MD, John W	York
BETANCOURT, MD, Sergio E	Allegheny
BETESH, MD, Joel S	Philadelphia
BETTINGER, MD, Robert	Allegheny
BETTS, DO, Brooks	Northampton
BETTS, MD, Eugene K	Philadelphia
BETZ, MD, Louis H	Union
BETZ, MD, Randal R	Philadelphia
BETZ, MD, William R	Montour
BEVAN, MD, Emma B	Philadelphia
BEVERLY, MD, Avery W	Philadelphia
BEVERLY JR, MD, Roland S	Philadelphia
BEVILACQUA, MD, Daniel F	Adams
BEVILACQUA, MD, John E	Philadelphia
BEVILACQUA JR, MD, Dante J	Delaware
BEYER, MD, H Jeanne	Centre
BEYER, DO, Robert A	Philadelphia
BEYER III, MD, Frederick C	Lancaster
BEYER JR, MD, Francis D	Westmoreland
BEYER JR, MD, Karl H	Philadelphia
BHAGAT, MD, Pragna R	Monroe
BHAGAT, MD, Rajesh G	Monroe
BHAGWANANI, MD, Drupadi G	Allegheny
BHARGAVE, MD, Usha A	York
BHARK, MD, Philip	Delaware
BHARUCHA, MD, Shernavaz D	Dauphin
BHASKAR, MD, Ambat G	Somerset
BHAT, MD, K Ramakrishna	Luzerne
BHATIA, MD, Shyamsunder	Montour
BHATNAGAR, MD, Yudhishter M	Clarion
BHATT, MD, Anjali G	Delaware
BHATT, MD, Gaurang P	Delaware
BHATT, MD, Naresh I	Washington
BHATT, MD, Prafulchandra U	Clinton
BHE, MD, H Kwan	Carbon
BHUTANI, MD, Vinod K	Philadelphia
BHUTTA, MD, Omar I	Allegheny
BHYUN, MD, Dae Soo	York
BIALAS, MD, Henry N	Berks
BIALAS, MD, Paul A	Warren
BIALAS, MD, Robert F	Delaware
BIANCA III, MD, Vincent C	Lackawanna
BIANCARELLI, MD, Edmund J	Lackawanna
BIANCO, MD, Antoni	Allegheny
BIANROSA, MD, John J	Philadelphia
BICHARA, MD, Wahib M	Delaware
BIDDLE, MD, John E	Lycoming
BIDULA, MD, Leo P	Allegheny
BIEBER, MD, Larien G	Lancaster
BIEBUYCK, MD, Julien F	Dauphin
BIELE, MD, Flora H	Philadelphia
BIEMULLER, MD, Martha L	Philadelphia
BIERER, MD, Edward D	Armstrong
BIERI, MD, John W	Dauphin
BIERMAN, MD, Joseph R	Lehigh
BIERMANN, MD, William A	Philadelphia
BIESINGER, MD, George J	Blair
BIEVER, MD, John A	Lebanon
BIGLAN, MD, Albert W	Allegheny
BIGLEY, MD, Joseph R	Philadelphia
BIGOS, MD, Edward T	Berks
BIKLE, MD, Charles A	Franklin
BIKLE, MD, H Dwight	Adams
BIKOWSKI, MD, Joseph B	Allegheny
BILANIUK, MD, Larissa T	Delaware
BILBAO, MD, Angel	Allegheny
BILDER, MD, Bruce M	Clinton
BILDER, MD, M Joan	Clinton
BILKER, MD, Iris J	Philadelphia
BILKO, MD, Thomas E	Luzerne
BILLAS, MD, Anthony	Northumberland
BILLIG, MD, Ruth A	Philadelphia
BINAKONSKY, MD, Harry S	Allegheny
BINDER, MD, Mitchell J	Lycoming
BINDIE, MD, Richard P	Schuylkill
BINNICK, MD, Steven A	Montgomery
BINNS, MD, Veronica	Fayette
BINSTOCK, MD, Harold	Allegheny
BIRD, MD, Luis J	Philadelphia
BIRDSALL, MD, Thomas M	Philadelphia
BIRKEL, MD, Paul A	Beaver
BIRNBAUM, MD, Michael D	Philadelphia
BIRO JR, MD, Frank	Northampton
BIRRELL, MD, Donald G	Allegheny
BISACCO, MD, Stephen J	Blair
BISBING, MD, John H	Berks
BISHOP, MD, David W	Blair
BISHOP, MD, Harry C	Philadelphia
BISHOP, MD, Poni S	Bradford
BISHOP, MD, Richard L	Bradford
BISHOP, MD, Robert P	Montgomery
BISHOP, MD, Sarah	Philadelphia
BISHOP, MD, Wayne E	Centre
BISHOW, MD, I Ralph	Philadelphia
BISIGNANI, MD, Gabriella M	Lackawanna
BISORDI, MD, Joseph E	Montour
BISSET JR, MD, James F	Northampton
BITETTO, MD, Nicola	Berks
BITMAN, MD, Harold L	Philadelphia
BITMAN, MD, Joseph	Philadelphia
BITMAN, MD, Kenneth L	Chester
BITNER, MD, Walter P	Dauphin
BITTENBENDER, MD, Joseph	Columbia
BITTINGER, MD, Ralph E	York
BIUCKIANS, MD, Edward	Bucks
BIXBY JR, MD, Edward W	Delaware
BIZOUSKY, MD, Franklin S	Jefferson
BIZUP, MD, Thomas	Schuylkill
BJORKLUND, MD, Mark D	Dauphin
BLACK, Francene W	Students
BLACK, MD, Judith E	Allegheny
BLACK, MD, Milton H	Allegheny
BLACK, MD, Perry	Philadelphia
BLACK, DO, Samuel J	Butler
BLACK JR, MD, Harry A	Allegheny
BLACK JR, MD, William A	Lackawanna
BLACKBURN, MD, Joseph M	Elk/Cameron
BLACKBURN, MD, Lawrence F	Westmoreland
BLACKBURN, MD, Robert E	Allegheny
BLACKBURN JR, MD, Laurence H	Bucks
BLACKER, MD, Bruce A	Philadelphia
BLACKLOW, MD, Robert S	Philadelphia
BLACKSMITH, DO, James E	Dauphin
BLACKSMITH, DO, William A	Dauphin
BLACKSMITH JR, MD, Gary L	Cumberland
BLADY, MD, John V	Philadelphia
BLAIR, MD, Albert J	Allegheny
BLAIR, MD, Frank W	Philadelphia
BLAISDELL, MD, C Theodore	Lehigh
BLAISURE, MD, Beverly C	Centre
BLAKE, MD, Douglas R	Lehigh
BLAKE, MD, Jeffery I	Erie
BLAKE, MD, Karl E	Allegheny
BLAKE, MD, Monroe O	Bradford
BLAKE, MD, Paul O	Delaware
BLAKE JR, MD, Alton D	Montgomery
BLAKESLEE, DO, Colson E	Jefferson
BLAKLEY, MD, John B	Allegheny
BLANCH, MD, Joseph J	Philadelphia
BLANCHARD, MD, Donovan C	Venango
BLAND, MD, C Brinley	Philadelphia
BLANK, MD, Ira B	Montgomery
BLANK, MD, Samuel	Philadelphia
BLANK, Susan	Allegheny
BLANNETT, MD, John D	Delaware
BLANZACO, MD, Andre C	Philadelphia
BLASCO, MD, Luis	Philadelphia
BLASIOLE, MD, Ralph S	Washington

BLASS, MD, David C	Fayette
BLATCHLEY, MD, Donald M	Westmoreland
BLATT, MD, Mark A	Philadelphia
BLAUM JR, MD, Louis C	Bradford
BLAUM SR, MD, Louis C	Luzerne
BLAUSER, MD, Robert B	Berks
BLECKER, MD, David	York
BLEEDEN, MD, Edward M	Delaware
BLEIER, MD, Adolph H	Delaware
BLESHMAN, MD, Michael H	Chester
BLESSING, MD, Henry G	Philadelphia
BLEWETT, MD, Charles H	Potter
BLEWITT, MD, George A	Philadelphia
BLIDNER, MD, Martin D	Luzerne
BLINDER, MD, Jeffrey S	Lehigh
BLINKOFF, MD, Barry A	Philadelphia
BLITZER, MD, Eleanor C	Philadelphia
BLIZZARD, MD, John J	Delaware
BLOCK, MD, Michael A	Armstrong
BLOCK, MD, Robert A	Philadelphia
BLOCK, MD, Robert C	Cambria
BLOCK, MD, Ronald M	Luzerne
BLOCK, MD, Steven	Bucks
BLOCKSTEIN, MD, Robert S	Allegheny
BLODGETT JR, MD, Randolph C	Montour
BLOES, MD, Walter S	Lackawanna
BLOM, MD, Bohen M F	Lycoming
BLOM, MD, Johannes	Lycoming
BLOMAIN, MD, E William	Lackawanna
BLOMAIN, MD, Eric W	Lackawanna
BLOOD JR, MD, Joseph B	Bradford
BLOOD JR, MD, Raymond G	Philadelphia
BLOOM, MD, Benjamin H	Philadelphia
BLOOM, MD, Edward I	Philadelphia
BLOOM, MD, James R	Allegheny
BLOOM, MD, Joseph	Philadelphia
BLOOM, MD, Joseph B	Allegheny
BLOOM, MD, Lawrence H	Philadelphia
BLOOM, MD, Marvin A	Westmoreland
BLOOM, MD, Steven M	Philadelphia
BLOOMFIELD, DO, Rachael M	Montgomery
BLORE JR, MD, James P	Bucks
BLOSCHICHAK, MD, Andrew	Luzerne
BLOTZER, MD, John W	York
BLOUGH, MD, Herbert A	Philadelphia
BLOUGH, MD, Leland S	Allegheny
BLUE, MD, Mark G	Allegheny
BLUE, MD, Vincent P	Bucks
BLUEMLE JR, MD, Lewis W	Philadelphia
BLUESTEIN, MD, David D	Allegheny
BLUESTEIN, MD, Hazel M	Montgomery
BLUESTONE, MD, Charles D	Allegheny
BLUM, MD, Bernard M	Philadelphia
BLUM, MD, Larry W	Philadelphia
BLUM, MD, Richard H	Luzerne
BLUMBERG, MD, Alexander W	Lycoming
BLUMBERG, MD, Baruch S	Philadelphia
BLUMBERG, MD, Leon D	Philadelphia
BLUMBERG, MD, Myron L	Philadelphia
BLUME, MD, Robert P	Allegheny
BLUMENSCHEIN, MD, Gertrude	Fayette
BLUMENTHAL, MD, Andrew R	Montgomery
BLUMENTHAL, MD, Charles	Philadelphia
BLUMENTHAL, MD, Jeffrey R	Bucks
BLUMSTEIN, MD, Charles G	Montgomery
BLUMSTEIN, MD, George I	Philadelphia
BLYTHE, MD, Peggy J	Washington
BOAL, MD, Danielle K	Dauphin
BOAL, MD, Erwin S	Beaver
BOAL, MD, Richard J	Dauphin
BOAL JR, MD, John H	Beaver
BOBAK, MD, Leopold	Fayette
BOBBY, DO, John L	Armstrong
BOBECK, MD, John J	Luzerne
BOBECK, MD, Joseph J	Luzerne
BOBEK, MD, Francis B	Lycoming
BOBEN, MD, William R	Luzerne
BOBICK, MD, Frank	Carbon
BOBIN, MD, John J	York
BOBROWSKI, Daniel	Students
BOCCAGNO, MD, Phillip A	Lackawanna
BOCHER, MD, Jack	Chester
BODE JR, MD, Frederick W	Allegheny
BODEK, MD, Alvin M	Allegheny
BODMER, MD, Meral O	Northumberland
BODNAR, MD, Timothy J	Mercer
BODNER, MD, Russell J	Philadelphia
BOEHMLER, MD, William J	Berks
BOEHNKE, MD, Manfred	Allegheny
BOGDANOFF, MD, Bruce M	Delaware
BOGDEWIC, MD, Thomas A	Allegheny
BOGER, MD, William P	Philadelphia
BOGIN, MD, Robert M	Philadelphia
BOGNER, MD, Edward W	Northumberland
BOGUCKI, MD, Edwin I	Delaware
BOHARAS, MD, Saul	Allegheny
BOHLENDER, MD, George P	Erie
BOHN, MD, Mark W	Luzerne
BOHNENBLUST, MD, Walter R	Schuylkill
BOHNENBLUST JR, MD, Walter R	Berks
BOHNER, MD, Mary F	Allegheny
BOICE, MD, G Newton	Allegheny
BOKSENBAUM, MD, Mervin	Allegheny
BOLAND, MD, Francis P	Lackawanna
BOLAND, MD, Stanley W	Lackawanna
BOLAND JR, MD, Francis B	Bucks
BOLANOVICH, MD, Lester J	Allegheny
BOLDEN, MD, Patrick T	Perry
BOLINE, George B	Allegheny
BOLINGER, MD, Mark S	Huntingdon
BOLLINGER, MD, James R	Chester
BOLMARCICH, MD, Virginia D	Delaware
BOLNO, DO, Charles M	Philadelphia
BOLOGNESE, MD, Ronald J	Philadelphia
BOLOTIN, MD, Joseph H	Mercer
BOLSTER, MD, Richard H	Chester
BOLTON, MD, Howard A	Allegheny
BOLUS, MD, Charles M	Lackawanna
BOMZE, MD, Jeffrey P	Philadelphia
BONACCI, MD, Richard J	Luzerne
BONACCORSI, MD, Diane T	Berks
BONADIO, MD, Peter M	Allegheny
BONAFEDE, MD, Peter L	Dauphin
BONAKDAR-POUR, MD, Akbar	Philadelphia
BONAN, MD, A Ferdinand	Philadelphia
BONANNI, MD, Craig C	Allegheny
BONCHEK, MD, Lawrence I	Lancaster
BONDI, MD, Edward Edge	Philadelphia
BONDI, MD, Frank R	Allegheny
BONDI, MD, Richard P	Allegheny
BONDY, MD, Thomas J	Cambria
BONEKEMPER, MD, Thomas W	Lehigh
BONESSI, MD, James V	Allegheny
BONESSI EXEC, SEC, Mrs Coby	Washington
BONET, MD, Luis	Allegheny
BONGIOVANNI, DO, Andrew G	Chester
BONI JR, MD, Dino R	Washington
BONIFACE, MD, Dolores J	Allegheny
BONITA, MD, Louis B	Luzerne
BONITA, MD, Raphael	Luzerne
BONNER, MD, Dennis J	Bucks
BONNER, MD, James F	Delaware
BONNER, MD, Mary J	Berks
BONNER, MD, Robert A	Lycoming
BONNER, MD, Robert E	Montgomery
BONNER JR, MD, Francis J	Montgomery
BONO, MD, John	Armstrong
BONONI, MD, Paula A	Montgomery
BONOS III, MD, Charles T	Lehigh
BONTEMPO, MD, Carl P	Beaver
BONTEMPO, MD, Franklin A	Beaver
BONTOMASE, MD, Jasper E	Lycoming
BONUCCI, MD, Bruno L	Fayette
BOO, MD, Ki T	Lehigh
BOOK, MD, Morris M	Beaver
BOOKERT, MD, Charles C	Allegheny
BOOKHAMMER, MD, Robert S	Philadelphia
BOONE, MD, Leslie J	Allegheny
BOONIN, MD, Alan	Luzerne
BOONSWANG, MD, Pricha	Northampton
BOONVISUDHI, MD, Thumrong	Fayette
BOOR, MD, John W	Delaware
BOOTH, MD, George	Allegheny
BOOTH JR, MD, Robert E	Philadelphia
BORA, MD, Gulderen N	Montgomery
BORAH, MD, Bishnu C	Bucks
BORAN, MD, Robert P	Schuylkill
BORDEN, MD, Anthony G	Philadelphia
BORDER, MD, Michael Wm	Allegheny
BORECKY, MD, David C	Cambria
BORELLI JR, Albert J	Students
BORENSTEIN, MD, Julius	Philadelphia
BORETSKY, MD, Harry	Allegheny
BORETSKY, MD, Robert H	Allegheny
BORGER, MD, Lee J	Warren
BORGIA, MD, Frank A	Allegheny
BORIOSI, MD, Guido D	Lackawanna
BORIS, Walter J	Students
BORJA, MD, Rogelio I	Armstrong
BORKOVIC, MD, Embrie J	Beaver
BORKOW, MD, Joel E	Cambria
BORKOWSKI, MD, Bernard B	Philadelphia
BORKOWSKI, MD, Winslow J	Philadelphia
BORNS, MD, Patricia F	Philadelphia
BORNSTEIN, MD, Barry	Clinton
BORNT, MD, Marsha D	York
BOROCHOVITZ, MD, Dennis	Allegheny
BORON, MD, Robert J	Clearfield
BORON, MD, Ronald L	Allegheny
BORON, MD, Stella M	Indiana
BOROW, MD, Lawrence S	Philadelphia
BOROW, MD, Sydney	Philadelphia
BOROWSKI, MD, Gregory D	Lackawanna
BOROWSKY, MD, Larry M	Philadelphia
BORRA, MD, Bolliaih	Luzerne
BORRISON, MD, Joseph A	Allegheny
BORTIN, MD, Leonard	Philadelphia
BORTNER, MD, Donald L	York
BORTZ, MD, Donald W	Westmoreland
BORUS, MD, Harry E	Allegheny
BOSACCO, MD, Stephen J	Philadelphia
BOSELLI, MD, Bruce D	Bradford
BOSLEY, MD, Thomas M	Philadelphia
BOSSE, MD, Milton D	Allegheny
BOTTA, MD, Samuel A	Allegheny
BOUCHER, MD, William F	Lehigh
BOURDAKOS, MD, Nicolas G	Allegheny
BOUVIER, MD, Marianne	Allegheny
BOUZARTH, MD, William F	Philadelphia
BOVE, MD, Frank A	Philadelphia
BOVE, MD, Richard L	Philadelphia
BOWEN, MD, Charles P	Allegheny
BOWEN, MD, Dale T	Lehigh
BOWEN III, MD, Adelbert	Allegheny
BOWEN JR, MD, Frank W	Philadelphia
BOWEN JR, MD, Thales	Montgomery
BOWER, MD, Harry B	Dauphin
BOWER, MD, James H	Dauphin
BOWER, MD, James N	Lawrence
BOWER, MD, John R	Berks
BOWER, MD, John Roebrich	Berks
BOWER, MD, Robert	Philadelphia
BOWER, MD, Robert J	Chester
BOWER, MD, Samuel C	Clinton
BOWERS, MD, David W	Lancaster
BOWERS, MD, Jeffery J	Delaware
BOWERS, MD, Leroy W	Blair
BOWERS, MD, Paul A	Philadelphia
BOWERS, Richard A	Students
BOWERS, MD, Roger P	Bradford
BOWES, MD, Donald E	Montour
BOWIE, MD, Morris A	Montgomery
BOWLING, MD, Chetwynd E	Philadelphia
BOWMAN, MD, David H	Blair
BOWMAN, MD, Herbert S	Dauphin
BOWMAN, MD, James E	Philadelphia
BOWMAN, MD, John H	Lancaster
BOWMAN, MD, Robert G	Allegheny
BOWMAN, MD, Sallyann	Philadelphia
BOWMAN JR, MD, Douglas F	Mckean
BOWMAN JR, MD, Thomas E	Dauphin
BOWRING, MD, Margaret A	Philadelphia
BOXER, MD, Arthur D	Montgomery
BOYD, MD, Dale W	Schuylkill
BOYD, MD, William J	Dauphin
BOYD III, MD, Robert T	Philadelphia
BOYEK, MD, Michael F	Bradford
BOYER, MD, George S	Lehigh
BOYER, MD, Randal A	Philadelphia
BOYER, MD, Walter E	Venango
BOYKIW, MD, Mark E	Indiana
BOYKIW, MD, Russell A	Clearfield
BOYLAN, MD, James J	Northampton
BOYLAN, MD, Raymond J	Allegheny
BOYLE, MD, Bruce C	Westmoreland
BOYLE, MD, Denis A	Chester
BOYLE, MD, Hugh G	Luzerne
BOYLE, MD, L Eamonn	York
BOYLE, MD, Richard C	Erie
BOYLE, MD, William H	Luzerne
BOYLER, MD, Lawrence J	Franklin
BOYSEN, MD, Homer	Schuylkill
BOYTIM, MD, Mark J	Philadelphia
BOZIC, MD, Albert F	Lycoming
BOZIC, MD, William F	Allegheny
BRABSON, MD, Howard W	Beaver
BRACE, MD, Frederick H	Philadelphia
BRACKBILL, MD, Elizabeth J	Berks
BRACKBILL, MD, Robert M	Berks
BRACKEN, MD, Mark M	Allegheny
BRACKIN, MD, George G	Bucks
BRACKIN, MD, Phillip S	Montgomery
BRACKIN JR, MD, John T	Montgomery
BRADEN, MD, Geoffrey L	Philadelphia
BRADEN JR, MD, Frank R	Allegheny
BRADFORD, MD, Bradley J	Allegheny
BRADFORD, MD, John D	Chester
BRADFORD, MD, Paul L	Montgomery
BRADLEY, MD, Betty H	Allegheny
BRADLEY, MD, Samuel M	Cambria
BRADLEY, MD, Vernon F	Blair
BRADLEY JR, MD, Robert H	Philadelphia
BRADLEY JR, MD, William A	Westmoreland
BRADLEY JR, MD, William P	Allegheny
BRADSHAW JR, MD, William A	Allegheny
BRADY, MD, Anna M	Philadelphia
BRADY, MD, Douglas F	Westmoreland
BRADY, MD, James P	Philadelphia
BRADY, MD, James S	Allegheny
BRADY, MD, John C	Luzerne
BRADY, MD, Joseph A	Montgomery
BRADY, Joseph J	Students
BRADY, MD, Luther W	Philadelphia
BRAGDON, MD, Robert W	Allegheny
BRAGG, MD, Phyllis A	Allegheny
BRAHMAKULAM, MD, Paul M	Mifflin/Juniata
BRAITMAN, MD, Robert A	Philadelphia
BRALLIER, MD, Hugh W	Westmoreland
BRALOW, MD, S Philip	Philadelphia
BRAMOWITZ, MD, Alan D	Allegheny
BRANAS, DO, John A	Lancaster
BRAND, MD, Carol E	Allegheny
BRANDFASS, MD, William T	Delaware
BRANDON, MD, John M	Washington
BRANDON, MD, Phyllis K	Armstrong
BRANDON, MD, William R	Allegheny
BRANDSTETTER, MD, Louis H	Allegheny
BRANDT, MD, John P	Clinton
BRANDT, MD, Robert I	Beaver
BRANDT, MD, Robert J	Northampton
BRANDY, MD, Dominic A	Allegheny
BRANELLA, MD, Anthony F	Delaware
BRANSCUM, MD, George P	Cumberland
BRANT, MD, Carl E	Westmoreland
BRANTON, MD, Leon N	Lehigh
BRASLOW, MD, Norman H	Delaware
BRASUK, MD, John L	Allegheny
BRAUN, MD, Daniel C	Allegheny
BRAUN, MD, Jean B	Fayette
BRAUN, MD, Thomas M	Washington
BRAUN III, MD, William P	Northampton
BRAUNEGG JR, MD, Paul W	Dauphin
BRAUNFELD, DO, Robert	Philadelphia
BRAUNSTEIN, MD, Steven A	Venango
BRAV, MD, Solomon S	Philadelphia
BRAVEMAN, MD, Bernard L	Allegheny
BRAY, MD, John S	Dauphin
BRAY, MD, Joseph B	Chester
BRAY, MD, Joshua C	Montgomery
BRAY, MD, Susan H	Philadelphia
BRAY, William C	Students
BRAYMAN, MD, Kenneth L	Philadelphia
BRAZEL, MD, Joseph F	Cumberland
BRECHER, MD, Eugene	Philadelphia
BRECHER, MD, Jeffrey A	Bucks
BRECKENRIDGE, MD, John W	Montgomery
BREEN, MD, Philip C	Montour
BREGMAN, MD, Joseph	Philadelphia
BREHM, MD, Hans H	Monroe
BREITE, MD, Herbert J	Bradford
BREITFELD, MD, Volker	Allegheny
BREMER, MD, Harry J	Cambria
BREN, DO, Deborah A	Lehigh
BRENEMAN, MD, John W	Franklin
BRENMAN, MD, Arnold K	Philadelphia
BRENNAN, MD, John P	Luzerne
BRENNAN, MD, Joseph E	Philadelphia
BRENNAN, MD, Leonard H	Warren
BRENNAN, MD, Richard E	Beaver
BRENNAN, MD, Robert W	Dauphin
BRENNAN, MD, Russell J	Philadelphia
BRENNAN, MD, William F	Allegheny
BRENNEMAN, MD, Paul G	Bucks
BRENNEMAN, MD, Richard E	Northampton
BRENNEN, MD, Robert F	Lehigh
BRENNER, MD, Barry S	Philadelphia
BRENNER, MD, Louis O	Dauphin
BRENNER, DO, Richard P	Philadelphia
BRENNER, MD, Sidney	Philadelphia
BRENNER, MD, Sophie A	Philadelphia
BRENNER JR, MD, Samuel S	Bradford
BRENT, Bradley H	Allegheny
BRENT, MD, Lawrence B	Allegheny
BRERETON, MD, Harmar D	Lackawanna
BRERETON, MD, William F	Erie
BRESLER, MD, R Ralph	Philadelphia
BRESLIN, MD, Joseph A	Lancaster
BRESLOW, MD, Irwin H	Philadelphia
BRESSI JR, MD, Thomas E	Montgomery
BREST, MD, Albert N	Philadelphia
BREST, MD, Norman A	Montgomery
BRESTICKER, David H	Allegheny
BRETHAUER JR, MD, Edward A	Allegheny
BRETT III, MD, George W	Beaver
BREVETTA, MD, Richard J	Mercer
BREWER, MD, Robert H	Lancaster
BREZIN, MD, Joseph H	Philadelphia
BRIANT JR, MD, William W	Allegheny
BRICE, MD, Judith A	Allegheny
BRICKER, MD, Samuel Q	Franklin
BRICKHOUSE, MD, Herman M	Lycoming
BRICKLEY, MD, Kenneth S	Clinton
BRICKNELL, MD, Paul P	Dauphin
BRIDENBAUGH, MD, Robert P	Blair
BRIDGENS, DO, Nancy K	Chester
BRIDGES, MD, Kenneth G	Philadelphia
BRIER, MD, Peter M	Cumberland
BRIGHTON, MD, Carl T	Philadelphia
BRIGNOLA, MD, Michael P	Philadelphia
BRILL, MD, David R	Montour
BRILL, MD, Francis W	Lackawanna
BRILL, MD, Joseph M	Delaware
BRILLMAN, MD, Jon	Allegheny
BRILLMAN, MD, Nathan	Philadelphia
BRILMYER, MD, George J	Luzerne
BRINDISI, MD, Gaetano	Philadelphia
BRINGHURST, MD, Louis S	Chester
BRINIG, MD, F Joseph	Erie
BRINK, MD, Earl J	Allegheny
BRINK, MD, William R	Lycoming
BRINKMEYER, DO, Scott D	Allegheny
BRISINI, MD, Patrick D	Cambria
BRISKIN, MD, Jonathan A	Delaware
BRISTER, MD, Neil W	Philadelphia
BRITT, MD, Edward C	Philadelphia
BRITTON, MD, L Lynne	Dauphin
BRIZUELA, MD, Hernan R	Philadelphia
BROAD, MD, Louis T	Philadelphia
BROADHEAD, MD, Richard	Allegheny
BROBYN, MD, Thomas J	Philadelphia
BROCK, MD, Charlene M	Philadelphia
BROCK, MD, David C	Blair
BROCK, MD, Richard R	Dauphin
BROCKMAN, MD, Stanley K	Philadelphia
BROCKMEYER, MD, Thomas F	Philadelphia
BROCKMYER, MD, M Lawrence	Erie
BROD, MD, Robert C	Delaware
BRODER, MD, George J	Philadelphia
BRODERMAN, MD, Susan J	Philadelphia
BRODIE, MD, Donald E	Bucks
BRODMERKEL JR, MD, George J	Allegheny
BRODOVSKY, MD, Harvey S	Philadelphia
BRODSKY, MD, Isadore	Philadelphia
BRODSKY, MD, Robert L	Allegheny
BRODSKY, MD, Steven G	Montgomery
BRODY, MD, Jerome I	Philadelphia
BRODY, MD, Julia B	Philadelphia
BRODY, MD, Morris W	Philadelphia
BROENNLE, MD, Albert M	Philadelphia
BROGAN, MD, Edmund J	Philadelphia
BROGAN, MD, John J	Philadelphia
BROGAN, MD, Louis E	Philadelphia
BROHM, MD, Charles G	Jefferson
BROMBERG, MD, Jonathan	Philadelphia
BROMMER, MD, Oliver R	Philadelphia

BRON, MD, Klaus M	Allegheny
BRONFMAN, MD, Howard J	Dauphin
BRONITSKY, MD, Barbara G	York
BRONITSKY, MD, Carl N	Dauphin
BRONSTEIN, MD, Howard D	Philadelphia
BRONSTEIN, MD, Judith B	Philadelphia
BRONSTEIN, MD, Robert M	Philadelphia
BRONSTEIN, MD, Seymour B	Luzerne
BROOK, MD, Gail S	Dauphin
BROOKS, MD, Charles M	Lehigh
BROOKS, MD, Daniel H	Allegheny
BROOKS, MD, Dennis L	Philadelphia
BROOKS, DO, Frank J	Clarion
BROOKS, MD, Frank P	Philadelphia
BROOKS, MD, Gerald M	Crawford
BROOKS, MD, Harry R	Dauphin
BROOKS, MD, James L	Greene
BROOKS, DO, John E	Clarion
BROOKS, DO, John M	Clarion
BROOKS, MD, Michael L	Delaware
BROOKS, MD, Robert	Philadelphia
BROOKS, MD, Ronald J	Montgomery
BROOKS III, MD, James L	Allegheny
BROOKS JR, MD, Clint E	Delaware
BROPHY, MD, Dow E	Cumberland
BROSCIUS, MD, Benjamin M	Northumberland
BROSELOW, MD, David D	Philadelphia
BROSNAN, MD, William J	Philadelphia
BROSS, MD, James E	Philadelphia
BROSSMAN, MD, Martin W	Lehigh
BROSTOFF, MD, Leon M	Allegheny
BROSTOFF, MD, Philip	Allegheny
BROTHERSON, MD, Gary T	Erie
BROTMAN, MD, Sheldon	Montour
BROUDO, MD, Samuel F	Philadelphia
BROUDY, MD, Arnold S	Allegheny
BROUGHER, MD, David E	Allegheny
BROUGHER, MD, Lear E	Allegheny
BROUSSARD, MD, Elsie R	Allegheny
BROWN, MD, Andrew J	Allegheny
BROWN, MD, Charles R	Allegheny
BROWN, MD, Christopher L	Lehigh
BROWN, MD, Clark E	Philadelphia
BROWN, MD, Donald C	Westmoreland
BROWN, MD, Doyle H	Bradford
BROWN, MD, Earl H	Montgomery
BROWN, MD, Elizabeth B	Delaware
BROWN, Elizabeth L	Students
BROWN, MD, Frederick G	Montour
BROWN, MD, Fredric S	Luzerne
BROWN, MD, Gary C	Philadelphia
BROWN, MD, George L	Montgomery
BROWN, MD, H Zane	Lancaster
BROWN, MD, Herman	Philadelphia
BROWN, MD, J Oliver	Philadelphia
BROWN, MD, John E	Erie
BROWN, MD, John L	Clinton
BROWN, MD, John M	Northampton
BROWN, MD, Kenneth R	Philadelphia
BROWN, MD, Manson	Venango
BROWN, DO, Marion L	Delaware
BROWN, MD, Matthew G	Mercer
BROWN, MD, Michael E	York
BROWN, Michael T	Students
BROWN, MD, Nathan	Chester
BROWN, MD, Ralph R	Indiana
BROWN, MD, Richard V	Allegheny
BROWN, MD, Robert B	Allegheny
BROWN, MD, Robert B	Franklin
BROWN, MD, Robert E	Lancaster
BROWN, MD, Robert L	Luzerne
BROWN, MD, Sheila	Northampton
BROWN, MD, Sylvan	Lackawanna
BROWN, MD, William E	Mercer
BROWN, MD, William E	Montgomery
BROWN 5TH, MD, Thomas W	Bucks
BROWN III, MD, Dewitt C	Montgomery
BROWN JR, MD, Frank E	Chester
BROWN JR, MD, James T	Allegheny
BROWN JR, MD, Joseph S	Mifflin/Juniata
BROWN JR, MD, Louis A	Philadelphia
BROWN JR, MD, M Evans	Montgomery
BROWN JR, MD, William C	Bucks
BROWN-BIEBER, MD, Dale E	Lebanon
BROWNE, MD, Laurence T	Philadelphia
BROWNE JR, MD, Earl Z	Philadelphia
BROWNSTEIN, MD, Bruce Keith	Montgomery
BROWNSTEIN, MD, Israel E	Philadelphia
BROWNSTEIN, MD, Phillip K	Philadelphia
BROZENA, MD, Stephen J	Philadelphia
BRUBAKER, MD, Elwood R	Berks
BRUBAKER, MD, J Kenneth	Lancaster
BRUBAKER, MD, Jacob H	Lancaster
BRUBAKER, MD, Paul E	Lancaster
BRUCE, MD, William B	Union
BRUCKER, MD, Paul C	Philadelphia
BRUEHLMAN, MD, Richard D	Allegheny
BRUNACCI, MD, Alfred W	Luzerne
BRUNDAGE, MD, John T	Lackawanna
BRUNDAGE, MD, Robert P	Lackawanna
BRUNGO, MD, James J	Allegheny
BRUNGO, MD, John A	Allegheny
BRUNGO, MD, John D	Allegheny
BRUNING III, Carl O	Allegheny
BRUNN JR, MD, Henry M	Allegheny
BRUNNER, MD, Richard A	Philadelphia
BRUNO, MD, Carman S	Allegheny
BRUNO, DO, Elena P	Philadelphia
BRUNO, MD, James R	Luzerne
BRUNO, MD, Jorge C	Allegheny
BRUNO, MD, Leonard A	Philadelphia
BRUNO, MD, Maria A	Westmoreland
BRUNO, MD, Pat J	Northumberland
BRUNO, MD, Stephen C	Allegheny
BRUNO JR, MD, Joseph N	Luzerne
BRUNO SR, MD, Joseph N	Luzerne
BRUNSKILL, MD, Dennis E	Allegheny
BRUNT JR, MD, Manly Y	Philadelphia
BRUTICO JR, MD, Carmen A	Lackawanna
BRUTON, MD, Charles W	Chester
BRYAN, MD, Frank S	Cumberland
BRYAN, MD, Thomas M	Dauphin
BRYAN JR, MD, John S	Bucks
BRYAN JR, MD, Ross E	Warren
BRYANT, MD, David W	Cumberland
BRYANT, MD, Frederick H	Philadelphia
BRYANT JR, MD, Winston M	Philadelphia
BRYLAWSKI, MD, Michael	Philadelphia
BRYSON, MD, Richard L	Lancaster
BRZEZIENSKI, Mark A	Students
BRZOZOWSKI, MD, Lawrence A	Berks
BU, MD, Tae-Hyung	Erie
BUB, MD, Barry	Berks
BUCAN, MD, Michael	Luzerne
BUCAR, MD, John R	Allegheny
BUCH, MD, David L	Bucks
BUCH, MD, Heriberto E	Philadelphia
BUCH, MD, Robert R	Lancaster
BUCH, MD, Sandhya Y	Berks
BUCHANAN, MD, Edwin B	Allegheny
BUCHANAN, MD, James L	Allegheny
BUCHANAN, MD, James R	Dauphin
BUCHANAN IV, MD, Harry W	Lehigh
BUCHDAHL, MD, Alice J	Allegheny
BUCHER, MD, Robert G	Bucks
BUCHERT, MD, Walter I	Montour
BUCHHEIT, MD, William A	Philadelphia
BUCHMAN, MD, David H	Indiana
BUCHMAN, MD, Robert R	Allegheny
BUCK, MD, Addison S	Montgomery
BUCK, MD, Ann L	Allegheny
BUCK, MD, Clarence J	Beaver
BUCK, MD, Keith K	Armstrong
BUCK, MD, Rudolph L	Allegheny
BUCK, MD, Ruth E	Montgomery
BUCKEY, MD, Joseph T	Luzerne
BUCKINGHAM, MD, Robert B	Allegheny
BUCKINGHAM, MD, Robert C	Dauphin
BUCKLEW, MD, Lawrence A	Allegheny
BUCKLEY, MD, Roland M	Philadelphia
BUCKLEY, MD, Ronald J	Lehigh
BUCKMAN, MD, Lewis T	Luzerne
BUCKMAN, MD, Paul S	Dauphin
BUCKMAN, MD, Samuel T	Luzerne
BUCKO JR, MD, Matthew I	Montgomery
BUCKTHAL, MD, Paul E	Bradford
BUCKWALTER, MD, Jeffrey A	Bucks
BUCKWALTER, MD, Phyllis S	Montgomery
BUCKWALTER, MD, Richard A	Montgomery
BUCS, MD, Roger G	Dauphin
BUCZKOWSKI, MD, Janet M	Allegheny
BUDD, MD, Robert M	Allegheny
BUDDE JR, MD, Richard B	Allegheny
BUDURA, MD, Paul	Northampton
BUENDIA, MD, Antonio V B	Northumberland
BUENDIA, MD, Mary Lou J	Northumberland
BUERGER JR, MD, George F	Allegheny
BUERK, MD, Minerva S	Montgomery
BUERKLIN, MD, Ellen M	Philadelphia
BUFFER JR, Sam A	Allegheny
BUFFONE, MD, David A	Jefferson
BUINEWICZ, Anna M	Students
BUINEWICZ, Brian R	Students
BUISER, MD, Rodolfo A	Mercer
BULATAO, MD, Agapito V	Berks
BULATOVIC, Annamaria	Students
BULETTE, MD, John L	Lehigh
BULGER, MD, Richard H	Blair
BULKLEY, MD, Andrew D	Bucks
BULLARD JR, MD, Ray E	Westmoreland
BULLINGTON, MD, Sunny J	Northumberland
BULLUCK, MD, David E	Philadelphia
BULOVA, MD, Stephen I	Philadelphia
BULSECO, MD, Patricia J	Allegheny
BUMAGIN, MD, Michael S	Lycoming
BUMGARDNER, MD, James L	Bucks
BUNAO, MD, Romulo M	Bradford
BUNDY, MD, Thomas W	Franklin
BUNESE, MD, Horst J	Philadelphia
BUNYA, MD, Vichai	Philadelphia
BUNYOR, MD, Agnes K	Huntingdon
BUONOCORE, MD, Bonnita K	Montgomery
BURAK, MD, Robert F	Luzerne
BURBRIDGE, MD, Geoffrey R	Erie
BURBRIDGE JR, MD, I Ralph	Erie
BURDEN, MD, Samuel S	Montgomery
BURDICK, MD, Mitchell	Erie
BURES, MD, J Conrad	Westmoreland
BURG, MD, Fredric D	Philadelphia
BURGARD, MD, Leonard A	Allegheny
BURGBACHER, MD, James S	Cambria
BURGER, MD, Joseph G	Beaver
BURGER, MD, Regis F	Allegheny
BURGER, MD, Theodore P	Northampton
BURGESS, MD, Geoffrey M	Chester
BURGET JR, MD, Dean E	Butler
BURGIN, MD, Walter H	Dauphin
BURKE, MD, Frank A	Montour
BURKE, Greg F	Students
BURKE, MD, M Susan	Montgomery
BURKE, MD, Patrick J	Luzerne
BURKE, MD, Peter R	Dauphin
BURKET, MD, Daniel G	Blair
BURKET, MD, Louis C	Blair
BURKET, MD, Ramon C	Blair
BURKETT, MD, Charles M	Allegheny
BURKETT, MD, Donald E	Cambria
BURKEY, MD, Fred J	Allegheny
BURKHARD JR, MD, Edward J	Lehigh
BURKHART, MD, Charles B	Montgomery
BURKHOLDER, MD, John A	Allegheny
BURKHOLDER, MD, Thomas O	Lehigh
BURKLE, MD, Joseph S	York
BURKLEY III, MD, Louis F	Northampton
BURKLEY JR, MD, Louis F	Northampton
BURKS, MD, John M	Lycoming
BURLAND, MD, J Alexis	Philadelphia
BURLINGAME, MD, Mark W	Lancaster
BURMEISTER, MD, Charles W	Bucks
BURNETT, MD, George W	Lancaster
BURNS, MD, Donald T	Berks
BURNS, MD, Frank D	Franklin
BURNS, MD, J Robert	Montour
BURNS, MD, Jesse E	Montgomery
BURNS, MD, Rhoda E	Philadelphia
BURNS, MD, William T	Dauphin
BURNS JR, MD, Charles N	Luzerne
BURNS SR, MD, Charles N	Luzerne
BURNSIDE, MD, John W	Dauphin
BURROS, MD, Harry M	Philadelphia
BURROWS, MD, Stanley B	Philadelphia
BURRY, MD, William C	Monroe
BURSALI, MD, Salahattin	Westmoreland
BURSTEIN, MD, Frank	Philadelphia
BUSCH, MD, Michael F	Lehigh
BUSCHIAZZO, MD, Horacio J	Philadelphia
BUSH, MD, Alton J	Armstrong
BUSH, MD, David C	Montour
BUSH, MD, Herman	Beaver
BUSH, MD, Stephen T	Cambria
BUSH, MD, William B	Dauphin
BUSH, MD, William M	Berks
BUSHKOFF, MD, Stanley H	Allegheny
BUSHWICK, MD, Bruce M	York
BUSHYAGER, MD, Ronald R	Westmoreland
BUSHYAGER, MD, Ross M	Montgomery
BUSILLO, MD, Nicholas A	Delaware
BUSIS, MD, Neil A	Allegheny
BUSIS, MD, Sidney N	Allegheny
BUSKO, MD, Carlton W	Lancaster
BUSLER JR, MD, Verne M	York
BUTCHER, MD, Richard J	Montour
BUTCHKO, MD, Andrew W	Mercer
BUTCOFSKI, MD, James S	Luzerne
BUTERA, MD, Vincent	York
BUTERBAUGH, MD, John C	Greene
BUTKIEWICZ, MD, Bernard L	Lycoming
BUTKO, Audrey C	Allegheny
BUTLER, MD, Anne K	Tioga
BUTLER, MD, Charles H	Chester
BUTLER, MD, Christopher L	Allegheny
BUTLER, MD, Horace G	Monroe
BUTLER, MD, Ivan L	York
BUTLER, MD, Melvin V	Philadelphia
BUTSON, MD, Harry E	Philadelphia
BUTT, MD, Hameed A	Luzerne
BUTT JR, MD, Frank H	Warren
BUTTERWORTH, MD, Thomas	Berks
BUXTON JR, MD, Donald R	Dauphin
BUYERS, MD, Robert A	Montgomery
BUZAS, MD, Jerome W	Berks
BUZBY, MD, Franklin S	Philadelphia
BUZBY, MD, Gordon P	Philadelphia
BUZZELLI, MD, Philip B	Allegheny
BUZZERD, MD, Harry W	Lycoming
BYBEL, Ann M	Students
BYERS, MD, James F	Allegheny
BYERS, MD, John A	Allegheny
BYERS, MD, Robert O	Erie
BYERS III, MD, James Wm	Philadelphia
BYLER, MD, Arthur B	Chester
BYLER, MD, David J	Erie
BYLER, MD, Philip R	Lycoming
BYRNE, MD, James E	Northampton
BYRNE, MD, Kevin J	Philadelphia
BYRNE, MD, Robert J	Montgomery
BYRNE, MD, Robert N	Chester
BYRNE, MD, William E	Dauphin
BYRON, MD, Harold J	Montgomery
BYRON, MD, Thomas W	Luzerne

C

CABALLE, MD, Jose B	Allegheny
CABRERA, MD, Rafael	Washington
CACCESE, MD, David M	Lehigh
CACCIAMANI, MD, John D	Lackawanna
CADIEUX, MD, Roger J	Dauphin
CADMAN, MD, Thomas E	Montour
CADY, MD, Joseph B	Bradford
CADY, MD, William W	Bradford
CAGGIANO, MD, John D	Chester
CAHAN, MD, Michael S	Philadelphia
CAHAN, MD, Robert B	Philadelphia
CAHILL, MD, John M	Bucks
CAHILL, MD, Thomas J	Montour
CAHN, MD, Milton M	Philadelphia
CAIN, MD, James P	Montgomery
CALABRO, MD, Sal P	Philadelphia
CALAMIA, DO, Joseph A	Montgomery
CALANDRA, MD, Gary B	Philadelphia
CALATA, MD, Eliseo R	Berks
CALBOT-SCZEPANSKI, MD, Cynthia L	Montgomery
CALCE, MD, John V	Lycoming
CALDER JR, MD, Joseph R	Lycoming
CALDERON, MD, Amador G	Union
CALDERON, MD, Celia S	Cambria
CALDERON, MD, Dominador C	Cambria
CALEB, MD, Mae H	Delaware
CALESNICK, MD, Benjamin	Philadelphia
CALHOUN, MD, Joseph H	Philadelphia
CALIGUIRI, MD, Joseph V	Allegheny
CALIGUIRI, MD, Lawrence A	Allegheny
CALISE, MD, Crescenzo G	Luzerne
CALKINS, MD, Joseph L	Lancaster
CALLAHAN, MD, Charles M	Berks
CALLAHAN, MD, Lawrence E	Allegheny
CALLAHAN, DO, Michael E	Potter
CALLCOTT-STEVENS, MD, Victor A	Franklin
CALLEN, MD, H Samuel	Lebanon
CALLENBERGER, MD, George J	Lycoming
CALLENBERGER, MD, Ronald W	Tioga
CALLERY, MD, Gerald E	Philadelphia
CALVELO, MD, Manuel G	Allegheny
CAMA, MD, Joseph	Bradford
CAMBEST JR, MD, Michael A	Allegheny
CAMBRIDGE, MD, Florinda L	Philadelphia
CAMERON, MD, Donald D	Luzerne
CAMERON, MD, Donald Y	Allegheny
CAMINOS, MD, Oliverio W	Allegheny
CAMITTA, MD, Francine D	York
CAMMARATA, MD, Roy J	Allegheny
CAMNITZ, DO, Leonard	Philadelphia
CAMODY-JOHNSTON, MD, Patricia A	Philadelphia
CAMP, MD, Mark O	Delaware
CAMP, MD, William P	Montgomery
CAMPANA, MD, Frederick T	Westmoreland
CAMPANA, MD, Joseph F	Lycoming
CAMPANA, MD, Louis F	Lycoming
CAMPANA, MD, Thomas J	Philadelphia
CAMPBELL, MD, Charles E M	Philadelphia
CAMPBELL, MD, David B	Dauphin
CAMPBELL, MD, David R	Columbia
CAMPBELL, MD, Duncan G	Allegheny
CAMPBELL, MD, Ernest W	Columbia
CAMPBELL, MD, G Robert	Beaver
CAMPBELL, MD, Jennifer H	Allegheny
CAMPBELL, Joseph D	Allegheny
CAMPBELL, MD, Neil P	Bucks
CAMPBELL, MD, Robert E	Philadelphia
CAMPBELL, MD, Robert J	Columbia
CAMPBELL, DO, Thomas M	Luzerne
CAMPBELL, MD, Thomas P	Allegheny
CAMPBELL, MD, Twining F	Montgomery
CAMPBELL, MD, William J	Dauphin
CAMPBELL JR, MD, James M	Centre
CAMPOS, MD, Luis I	Lehigh
CANALS, MD, Joaquin	Montgomery
CANCELMO, MD, J James	Montgomery
CANCELMO, MD, John B	Chester
CANDELARIA, MD, Josefina M	Allegheny
CANDER, MD, Leon	Philadelphia
CANDIO, MD, Joseph A	Lehigh
CANE, MD, Martin	Philadelphia
CANINO, MD, Christopher W	Philadelphia
CANN III, MD, Thomas W	York
CANNER, MD, Gary C	Berks
CANNON, MD, Dawn L	Philadelphia
CANNON, MD, Edward J	Philadelphia
CANTELLOPS, MD, Jose M	Allegheny
CANTER, MD, Donald	Philadelphia
CANTER, MD, Harry E	Allegheny
CANTER, MD, Hyman E	Allegheny
CANTERNA, MD, Anthony C	Washington
CANTOR, MD, Harry	Philadelphia
CANUSO, MD, Nicholas A	Philadelphia
CAPAROSA, MD, Ralph J	Allegheny
CAPLAN, MD, Aaron	Lawrence
CAPLAN, MD, Bernard	Philadelphia
CAPLAN, MD, Howard S	Philadelphia
CAPLAN, MD, Milton L	Lawrence
CAPLAN, MD, Murray S	Philadelphia
CAPLAN, MD, Paul S	Allegheny
CAPO, Angela T	Students
CAPOBIANCO, MD, Frank M	Northampton
CAPOBRES JR, MD, Rudolfo M	Washington
CAPONE, MD, Gaetano J	Philadelphia
CAPONE, MD, Ralph A	Westmoreland
CAPONE JR, MD, Raymond A	Allegheny
CAPPA, MD, Robert J	Berks
CAPPARELL, MD, Homer V	Allegheny
CAPPIELLO, MD, Justin L	Lancaster
CAPPIELLO, MD, William A	Bucks
CAPPIELLO, MD, William F	Bucks
CAPPOLA JR, MD, Michael T	Philadelphia
CAPPUCCIO, MD, Matthew S	Philadelphia
CAPRINI, MD, Emilia M	Allegheny
CAPUTO, MD, Larry A	Philadelphia
CAPUZZI, MD, David M	Philadelphia
CARABASI, MD, R Anthony	Philadelphia
CARABASI, MD, Ralph A	Philadelphia
CARABELLI, MD, Robert A	Philadelphia
CARABELLI, MD, Ronald J	Philadelphia
CARABELLO, MD, Charles A	Berks

CARAIMAN, MD, Myron	Allegheny
CARAMANNA, MD, James F	Allegheny
CARAPELLA, MD, John D	Lehigh
CARAPELLOTTI, MD, Richard A	Philadelphia
CARAZOLA, MD, Joseph H	Washington
CARBAUGH, MD, Howard L	Lehigh
CARBO, DO, Anthony P	Delaware
CARBONI, MD, Vincent A	Luzerne
CARDAMONE, MD, S Joseph	Philadelphia
CARDELLINO, MD, Thomas J	Cambria
CARDENAS, MD, Florencio P	Fayette
CARDLIN, MD, Kenneth M	Dauphin
CAREL, MD, Warren D	Philadelphia
CARELLA, MD, Richard J	Montgomery
CARETTI, MD, J William	Westmoreland
CAREY, Andrew B	Students
CAREY, MD, Ann E	Dauphin
CAREY, MD, Edward J	Luzerne
CAREY, MD, Eva S	Allegheny
CAREY, MD, John L	Luzerne
CAREY, MD, John T	Beaver
CAREY, MD, Kevin V	Bradford
CAREY, MD, Philip D	Cumberland
CAREY, MD, William B	Delaware
CARHART, MD, Judy A	Dauphin
CARIM, MD, Hyder M	Berks
CARIM, MD, Moiz M	Berks
CARINO, MD, Mariel G	Lackawanna
CARL, MD, David A	Bradford
CARL, MD, Gary H	Allegheny
CARLIN, MD, Elwin S	Montgomery
CARLIN, MD, Gerald J	Allegheny
CARLINI, MD, Charles J	Allegheny
CARLINO, MD, James T	Jefferson
CARLOS, MD, Hector D	Bucks
CARLOW, MD, Joseph F	Chester
CARLSON, MD, Ardyce R	Adams
CARLSON, MD, Clifford H	Bradford
CARLSON, MD, Eric J	Delaware
CARLSON, MD, John P	Montour
CARLSON, MD, Kenneth E	Beaver
CARLSON, MD, Robert E	Montgomery
CARLSON, MD, Stephen E	Berks
CARLSON JR, MD, John A	Philadelphia
CARLUCCI, MD, Ronald J	Philadelphia
CARMEN, Thomas F	Students
CARMICHAEL, MD, Paul L	Montgomery
CARNABUCI, MD, Guy J	Philadelphia
CARNEVAL, Patricia A	Allegheny
CARNEY, MD, David P	Lehigh
CARNEY, MD, Frank T	Cambria
CARNEY, MD, Paul L	Centre
CAROFF, MD, Romuald J	Cambria
CAROLINE, MD, Dina F	Philadelphia
CAROLIPIO, MD, Reynaldo R	Lawrence
CARP, MD, Albert A	Philadelphia
CARP, MD, Leon M	Philadelphia
CARP, MD, Mason J	Dauphin
CARPENTER, MD, Cathy P	York
CARPENTER, MD, Kim L	York
CARPENTER IV, MD, E Joel	Lehigh
CARPENTER JR, MD, John T	Montgomery
CARR, MD, James V	Allegheny
CARR, MD, William F	Dauphin
CARRASCO, MD, Mary M	Allegheny
CARRELL, MD, Robert L	Allegheny
CARRIER, MD, Ralph E	Centre
CARROLL, DO, Edmund T	Bucks
CARROLL, MD, Laurence E	Lancaster
CARROLL, MD, Nancy E	Allegheny
CARROLL, MD, Robert J	Allegheny
CARROLL, MD, Robert T	Philadelphia
CARROLL, MD, Stanton F	Philadelphia
CARROZZA, MD, Harry D	Philadelphia
CARRUTHERS, MD, Ralph B	Lancaster
CARSON, MD, Donald G	Allegheny
CARSON, MD, John S	Montgomery
CARSON, Teresa C	Students
CARSON, MD, Thomas E	Warren
CARSON III, MD, John N	York
CARSON JR, MD, Winfield B	Allegheny
CARTER, MD, Debbie R	Philadelphia
CARTER, MD, Donald L	Westmoreland
CARTER, MD, Howard A	Cambria
CARTER, MD, J Stephen	Westmoreland
CARTER, MD, Jan O	Allegheny
CARTER, MD, Joseph H	Erie
CARTER, MD, Judith H	Allegheny
CARTER, MD, Thomas L	Huntingdon
CARTER, W Bradford	Students
CARTER, MD, William A	Lancaster
CARTER JR, MD, Joseph H	York
CARTER JR, MD, William S	Montgomery
CARTY, MD, Sally E	Dauphin
CARTY JR, MD, James B	Montgomery
CARUSO, MD, David M	Elk/Cameron
CARUSO, MD, Mark P	Montgomery
CARUSO JR, MD, John	Bucks
CARVAJAL, MD, Roberto T	Bucks
CARVER, MD, Joseph R	Philadelphia
CARVER, MD, Margaret A	Fayette
CARY, MD, Gene L	Dauphin
CARZO, MD, Cynthia G	Allegheny
CASADAY, MD, Floyd M	Indiana
CASAL, MD, Rolando A	Dauphin
CASALE, MD, Lawrence F	Cambria
CASALE, MD, Louis J	Bucks
CASE JR, MD, Warren G	Philadelphia
CASERIO, MD, Rebecca J	Allegheny
CASEY, MD, John D	Philadelphia
CASEY, MD, Kevin	Philadelphia
CASEY, MD, Michael P	Philadelphia
CASEY, MD, Michael P	Allegheny
CASEY, MD, Paul R	Philadelphia
CASHDOLLAR, MD, Michael R	Franklin
CASHMAN, MD, William M	Warren
CASIMO, MD, Matthew A	Allegheny
CASPER, MD, Daniel R	Westmoreland
CASSEL, MD, Franklin K	Lancaster
CASSEL, MD, Gary H	Philadelphia
CASSEL, MD, John J	Lehigh
CASSEL, MD, R Douglas	Dauphin
CASSELBERRY, MD, E Josephine	Northampton
CASSELL, Ian L S	Students
CASSELMAN, MD, Hyman L	Erie
CASSENS, MD, Brett J	Philadelphia
CASSIDY, MD, Harvey D	Montour
CASSIDY, MD, Joseph A	Blair
CASSIDY, MD, William J	Philadelphia
CASSOFF, MD, Richard G	Allegheny
CASSONE, MD, Gary J	Lackawanna
CASTAGNA, MD, Armand	Philadelphia
CASTEL, MD, Jose M	Montgomery
CASTELLANO, MD, Thomas J	Luzerne
CASTELLI, MD, Dario D	Allegheny
CASTELLON, MD, Mireya A	Cambria
CASTELLON-VOGEL, MD, Carlos H	Cambria
CASTERLINE, MD, Charlotte L	Luzerne
CASTERLINE, MD, Peter F	Luzerne
CASTILLENTI, MD, Guy A	Allegheny
CASTILLO, MD, Francisco A	Westmoreland
CASTILLO, MD, Jose	Philadelphia
CASTILLO, MD, Manuel M	Allegheny
CASTLE, MD, Charles A	Lancaster
CASTOR, MD, Louis H	Philadelphia
CASTRINA JR, MD, Frank P	Cumberland
CASTRO, MD, Arturo F	Allegheny
CASTRO, MD, Augusto D	Allegheny
CASTROVINCI, MD, Robert V	Philadelphia
CASWELL, MD, Horace T	Philadelphia
CATALANO, MD, Kathleen F	Westmoreland
CATALANO JR, MD, Louis W	Westmoreland
CATENA, MD, Elizabeth P	Allegheny
CATENA, MD, Michael R	Allegheny
CATENA JR, MD, William P	Allegheny
CATLIN, MD, Robin J O	Berks
CATTIE, MD, Vincent J	Philadelphia
CATTON, MD, Domenic J	Blair
CATTON, MD, Raymond M	Chester
CAUFFMAN, MD, William J	Bucks
CAULFIELD III, Walter H	Allegheny
CAUTILLI, MD, Richard A	Montgomery
CAVA, MD, Joseph J	Philadelphia
CAVAN, MD, Albina B	Luzerne
CAVAN, MD, John F	Luzerne
CAVANAUGH, MD, Michael F	Montgomery
CAVANAUGH JR, MD, Francis J	Allegheny
CAVASINA, MD, Mary M	Washington
CAVE, MD, Sergil L	Philadelphia
CAVENDER, MD, John C	Susquehanna
CAVOTO, MD, Michael J	Indiana
CAWOG, MD, Antoine F	Westmoreland
CECH, MD, Rosanne	Lackawanna
CEDRONE, MD, Francine Anne	Philadelphia
CEFARATTI, MD, Michael D	Berks
CELANI, MD, Victor J	Delaware
CELEBRE, MD, Joan A	Montgomery
CELKO, MD, David A	Allegheny
CELLINI, MD, L Luke	Delaware
CENEDELLA, MD, Stephen C	Venango
CEPEDA, MD, Elvessa P	Philadelphia
CERA JR, MD, Peter J	Montour
CERASO, MD, Louis C	Westmoreland
CERCIELLO, MD, Mark J	Lehigh
CERCONE, DO, David	Allegheny
CERIANI, Carol M	Allegheny
CERIMELE, MD, Nicholas A	Cambria
CERNE, MD, Andrew J	Westmoreland
CERON, MD, Gabriel	Wayne/Pike
CERRA, MD, Carmine J	Monroe
CERTO, MD, Salvatore A	Allegheny
CERUL, MD, Maurice S	Allegheny
CESARE, MD, Joseph G	Lackawanna
CESTELLO, MD, Robert J	Allegheny
CEVALLOS, MD, Eduardo A	Bucks
CHABON, MD, Robert S	Allegheny
CHABRA, MD, Mohan L	Allegheny
CHADAGA, MD, Pandeswaram	Schuylkill
CHADWICK, MD, Harold H	Bradford
CHAFFEE, MD, John S	Erie
CHAI, MD, Chiu L	Bucks
CHAI, MD, Min S	Lackawanna
CHAIT, MD, Arnold	Philadelphia
CHAITOFF, MD, Kevin A	Allegheny
CHALAL, MD, Gerald S	Philadelphia
CHALAL, MD, Kenneth	Philadelphia
CHALEFF, Frederick M	Students
CHALETT, MD, Jonathan M	Philadelphia
CHALFANT, MD, John C	Blair
CHALFANT, MD, Richard S	Allegheny
CHALLINOR, MD, Robert B	Allegheny
CHALLINOR, MD, S Boyd	Allegheny
CHAMBERLAIN, MD, William H	Bucks
CHAMOVITZ, MD, Bruce N	Beaver
CHAMOVITZ, MD, David L	Beaver
CHAMOVITZ, MD, Irvin	Allegheny
CHAMOVITZ, MD, Jerome	Allegheny
CHAMOVITZ, MD, Robert	Allegheny
CHAMPAGNE, MD, Emily M	Allegheny
CHAN, MD, Anne K	Philadelphia
CHAN, MD, Daniel M	Franklin
CHAN, MD, Siu Won	Bucks
CHANDRA, MD, Prasanta C	Philadelphia
CHANDRA-MOHAN, MD, Avverahalli M	Luzerne
CHANDRAN, MD, Gopalaswamy	Cambria
CHANDRASEKARAN, MD, Ramamurti	Allegheny
CHANDRASEKARAN, MD, Sannasie	Westmoreland
CHANG, MD, Alexander C S	Allegheny
CHANG, MD, Byung D	Perry
CHANG, MD, Charles H	Westmoreland
CHANG, MD, Chris C	Dauphin
CHANG, MD, Chun S	Luzerne
CHANG, MD, Clayton W	Montgomery
CHANG, MD, Helena R	Philadelphia
CHANG, MD, In-Ho	Lehigh
CHANG, MD, Kun T	Philadelphia
CHANG, MD, Myunghwan	Berks
CHANG, MD, Raymond G	Erie
CHANGCO, MD, Alvaro N	Washington
CHANNAPATI, MD, Thippeswamy	Butler
CHANNICK, MD, Bertram J	Philadelphia
CHAPA, MD, Sukumar M	Clarion
CHAPIS, MD, Nicholas J	Montgomery
CHAPLIN, MD, Stanley S	Philadelphia
CHAPMAN, MD, Albert L	Dauphin
CHAPMAN, MD, John H	Montour
CHAPMAN, Norman A	Students
CHAPMAN, MD, William L	Allegheny
CHAPPELKA, MD, Alfred R	Philadelphia
CHAREPOO, MD, Khashaiar	Warren
CHARKES, MD, N David	Philadelphia
CHARLESWORTH, MD, Ernest E	Somerset
CHARLSON, MD, Murray T	Allegheny
CHARLTON, MD, Brian L	Bradford
CHARLTON, MD, Glenn B	Mercer
CHARNEY, MD, Richard H	Bucks
CHARNOCK, MD, Maurice P	Northampton
CHARNY, MD, Charles W	Philadelphia
CHASE, MD, Harold F	Philadelphia
CHASE, MD, Jeffrey S	Philadelphia
CHASE, MD, William D	Centre
CHASLER, MD, Nicholas L	Washington
CHASTENEY III, MD, Edward A	Philadelphia
CHAT, MD, Emanuel	Philadelphia
CHATHA, MD, Iftikhar A	Mercer
CHATREE-DUANGNET, MD, Chad	Lawrence
CHAUDHRY, MD, Mohammad A	Monroe
CHAUDHRY, MD, Rahat M	Allegheny
CHAUDHRY, MD, Sakina A	Monroe
CHAUHAN, MD, Ambaram V	Allegheny
CHAVERN, MD, Hugh E	Westmoreland
CHAVES, MD, Fernando	Somerset
CHAVIN, Kenneth D	Students
CHAWLA, MD, Harish C	Bucks
CHAWLA, MD, Shanta	Bucks
CHAWLUK, MD, John B	Philadelphia
CHAYAPRUKS, MD, Prayun	Greene
CHEADLE, MD, Margaret J	Tioga
CHEAH, MD, Beng-Hong	Schuylkill
CHEEVER, MD, Francis S	Allegheny
CHEKE, Laird J	Allegheny
CHELEN, Carl J	Students
CHELIUS, MD, Alan B	Berks
CHEN, MD, Chijen	Delaware
CHEN, MD, Henry Y	Venango
CHEN, MD, Juh-Huey	Lehigh
CHEN, MD, Mao Hsiung	Philadelphia
CHEN, MD, Wei-Fan	Philadelphia
CHENEY, MD, David M	York
CHENG, MD, Chun-Pin	Allegheny
CHENG, MD, David T L	Allegheny
CHENG, MD, Harvey S	Lehigh
CHENG, MD, Lawrence C	Lehigh
CHENGAPPA, MD, Palecanda P	Allegheny
CHENSEE, MD, Jasper G	Berks
CHEPKO, MD, Margaret I	Allegheny
CHEPONIS, MD, George B	Allegheny
CHERIAN, MD, George R	Jefferson
CHERNER, MD, Rachmel	Philadelphia
CHERNEY, MD, Paul J	Philadelphia
CHERNOFF, MD, Arthur	Philadelphia
CHERNOFF, MD, Benjamin	Philadelphia
CHERNOFF, MD, Robert W	Delaware
CHERRY, MD, Louis J	Jefferson
CHERRY, MD, Scott M	York
CHERRY, MD, Steven B	Cumberland
CHERUP, MD, E David	Allegheny
CHERVONY, MD, Daniel E	Philadelphia
CHESEN, MD, David	Philadelphia
CHESEN, MD, Neil	Philadelphia
CHESIN, MD, Carole M K	Allegheny
CHESNICK, MD, Steven R	Montgomery
CHESTNUT, MD, Wendell	Philadelphia
CHETLIN, MD, Sherwood M	Allegheny
CHETLIN, MD, Stuart H	Allegheny
CHETT, MD, Nicholas J	Berks
CHEUNG, MD, Hoo J	Blair
CHEYNEY II, MD, James B	Montgomery
CHI, MD, Nungja	Philadelphia
CHIAVACCI, MD, Wayne E	Lackawanna
CHICKLO, MD, James M	Franklin
CHICO, MD, Lauro V	Allegheny
CHICOTE, MD, Alfredo L	York
CHIDESTER, MD, John H	Chester
CHIDI, MD, Joseph C	Potter
CHIGER, Judith L	Students
CHIKARMANE, MD, Ajit M	Luzerne
CHIKARMANE, MD, Kalpana A	Luzerne
CHILD, MD, Proctor L	Lehigh
CHILDS, MD, Elizabeth R	Allegheny
CHILDS, MD, James E	Armstrong
CHILDS, MD, John N	Philadelphia
CHILDS, MD, Marion C	Chester
CHILIAN JR, MD, Stephen A	Elk/Cameron
CHIN, MD, Byoung Kwon	Bucks
CHINITZ, MD, Joel L	Philadelphia
CHIRICO, MD, Anna-Marie	Philadelphia
CHIRIELEISON, MD, Rocco F	Berks
CHIRIGOS, MD, Gregg G	Allegheny
CHISDAK, MD, Michael W	Bradford
CHISUM, MD, Melvin J	Philadelphia
CHLUDZINSKI, MD, Ronald W	Allegheny
CHMIELEWSKI, MD, Robert E	Philadelphia
CHO, MD, Doo W	Blair
CHO, MD, Jay J	Dauphin
CHO, John M	Allegheny
CHO, MD, Jong S	Fayette
CHO, MD, Sang Y	Philadelphia
CHO, MD, Yong D	Washington
CHOBY, MD, John J	Bucks
CHODROFF, MD, Charles H	Lebanon
CHOGICH, MD, John C	Delaware
CHOI, MD, Byong L	Bucks
CHOI, MD, Edward M	Luzerne
CHOI, MD, John K K	Dauphin
CHOI, MD, Kwang Y	Crawford
CHOI, MD, Sang Y	Franklin
CHOI, MD, Sean H	Allegheny
CHOI, MD, Tohshik	Montgomery
CHOLAPRANEE, MD, Rewat	Allegheny
CHOLLAK, MD, Joseph P	Luzerne
CHOLLAK, MD, William L	Philadelphia
CHOMSKY, MD, David E	Philadelphia
CHONG, MD, Daniel C	Allegheny
CHOONG, MD, Shung S	Schuylkill
CHOPRA, MD, Raj P	Columbia
CHOPRA, MD, Ramesh K	Blair
CHORAZY, MD, Anna J	Allegheny
CHORAZY, MD, Zdzislaw J	Beaver
CHOTI, MD, Michael A	Philadelphia
CHOTINER, MD, Bennett	Dauphin
CHOU, MD, Vivian K	Allegheny
CHOUGH, MD, Andrew C B	Allegheny
CHOWDHRY, MD, Zafar I	Armstrong
CHOWDHURY, MD, A Rab	Berks
CHREMOS, MD, Athanassios N	Philadelphia
CHRIST, MD, Nicholas J	Berks
CHRISTENSEN, MD, David W	Berks
CHRISTENSON, MD, Catherine M	Beaver
CHRISTIAN, MD, Horace D	Allegheny
CHRISTIAN, MD, Robert	Allegheny
CHRISTIANSEN, MD, Kjell H	Montgomery
CHRISTIANSON, MD, Alan D	Westmoreland
CHRISTIDES, MD, Stephan A	Philadelphia
CHRISTIE, MD, Joan A	Philadelphia
CHRISTIE, MD, Karl B	Allegheny
CHRISTIE, MD, Thomas	Chester
CHRISTMAN, MD, James C	Franklin
CHRISTMAN, MD, Willard W	Northumberland
CHRISTOFORETTI, MD, Russell J	Washington
CHRISTOU, MD, Aristotle A	Philadelphia
CHRISTY, MD, Michael G	Allegheny
CHRISTY, MD, Wallace C	Allegheny
CHROMIAK, MD, S Blaise	Dauphin
CHRZANOWSKI, MD, Robert T	Delaware
CHU, MD, Ann M	Philadelphia
CHU, MD, Donald	Philadelphia
CHU, MD, Jennifer	Philadelphia
CHU, MD, Winston	Erie
CHUA, MD, Chong V	Montgomery
CHUENSUMRAN, MD, Ongart	Allegheny
CHUENSUMRAN, MD, Rajani S	Allegheny
CHUGHTAI, MD, Arshad I	Allegheny
CHUN, MD, Sae-Il	Philadelphia
CHUN, MD, Yoon-Taek	Monroe
CHUNG, MD, C Kun	Lackawanna
CHUNG, MD, Chin D	Lawrence
CHUNG, MD, Chin-Yong	Erie
CHUNG, MD, Edward K	Philadelphia
CHUNG, MD, Hack R	Montgomery
CHUNG, MD, Hi-Young	Luzerne
CHUNG, MD, Kwang H	Allegheny
CHUNG, MD, Whan S	Philadelphia
CHUNG, MD, Yoon Jin	Westmoreland
CHURCH, MD, Paul A	Lehigh
CIACCI, MD, Vincent W	Chester
CIANCIULLI, MD, Francis D	Delaware
CIANFRANI, MD, Peter M	Bucks
CIANNI, MD, Ronald J	Lackawanna
CIAVARELLI, MD, Anthony G	Montgomery
CIBIK, MD, Lisa M	Allegheny
CICCARELLI, MD, Clem A	York
CICCARELLI, MD, Harold E	Allegheny
CICCARELLI, MD, Lee M	Lycoming
CICCHIELLO, MD, James R	Northumberland
CICCHINO, MD, Frank E	Allegheny
CICCO, MD, Robert C	Allegheny

CICCONE, MD, Emmett F	Philadelphia
CICCONE, MD, Patrick E	Montgomery
CICHELLI, MD, Andrew V	Philadelphia
CICHON, MD, Philip J	Allegheny
CIENCIVA, MD, Rosemaria J	Elk/Cameron
CIESIELKA, MD, Kenneth	Allegheny
CIESLA, MD, William P	Adams
CIGANIC, MD, Ratimir R	Allegheny
CIGNETTI, MD, Franklin E	Allegheny
CINBERG, MD, Leonard A	Philadelphia
CINCALA, DO, Robert P	Allegheny
CINCO, MD, Victorio B	Chester
CINCOTTA, MD, Janet F	Dauphin
CINCOTTA, MD, Joseph A	Dauphin
CINELLI, MD, Cleto G	Berks
CIOTOLA, MD, Augustine A	Luzerne
CIOTOLA, MD, Thomas J	Luzerne
CIPOLLA, MD, Charles F	Lycoming
CIRELLI, MD, Mario G	Philadelphia
CITRO, MD, Laurence A	Berks
CITRONE, MD, Peter J	Allegheny
CIVITARESE, MD, Louis R	Allegheny
CLADEL, MD, Charles E	Dauphin
CLADER, MD, Stanley C	Montgomery
CLAIR, MD, Theodore W	Montgomery
CLAMPITT, MD, Robert V	Dauphin
CLANCY, MD, Michael	Philadelphia
CLARDY, John M	Students
CLARE, MD, David W	Allegheny
CLARE, MD, Henry E	Delaware
CLARE, MD, Timothy P	Allegheny
CLARK, MD, Ann K	Westmoreland
CLARK, MD, David P	Lebanon
CLARK, MD, Donald L	Philadelphia
CLARK, MD, Eddie L	Philadelphia
CLARK, MD, Grant C	Columbia
CLARK, MD, James E	Delaware
CLARK, MD, John K	Philadelphia
CLARK, MD, Joseph G	Chester
CLARK, MD, Joseph M	Lebanon
CLARK, MD, Lawrence M	Clarion
CLARK, MD, Mark C	Philadelphia
CLARK, MD, Mary D	Indiana
CLARK, MD, Sandra M	Clarion
CLARK, MD, William H	Allegheny
CLARKE, MD, Ann E	Montgomery
CLARKE, MD, Charles E	Allegheny
CLARKE, MD, Franklyn R	Bucks
CLARKE, MD, Frederick T	Northampton
CLARKE, MD, John R	Philadelphia
CLARKE, MD, Leon E	Philadelphia
CLARKE, MD, Robert H	Allegheny
CLASSEN, MD, Charles H	Montgomery
CLAUHS, MD, Ronald P	Chester
CLAUSS, MD, Thomas F	Lackawanna
CLAY, MD, Bettie W	Chester
CLAYTON, DO, John S	Chester
CLAYTON, MD, Richard J	Chester
CLAYTON, MD, Thomas D	Chester
CLAYTON JR, MD, Samuel T	Dauphin
CLEARFIELD, MD, Harris R	Philadelphia
CLEARFIELD, MD, Ronald J	Westmoreland
CLEAVER, MD, Clarence P	Columbia
CLEAVER, MD, Dorothy M	Montgomery
CLEAVER, MD, E Eugene	Montgomery
CLELAN, MD, George M	Lancaster
CLELAND, MD, Charles E	Mckean
CLELAND, MD, James W	Delaware
CLELAND, MD, M Elizabeth	Mckean
CLEMENS, MD, Thomas M	Lebanon
CLEMENT, MD, Gordon S	Montgomery
CLEMENT, MD, John A	Montour
CLEMENTS, MD, David H	Westmoreland
CLEMENTS, MD, Harry H	Allegheny
CLEMENTS, MD, James K	Washington
CLEMENTS, MD, William T	Berks
CLEMENTS, MD, William W	Montgomery
CLERF, MD, Louis H	Philadelphia
CLEVELAND, MD, Albert F	Delaware
CLEVENGER, MD, Robert W	Allegheny
CLEVER, MD, John E	Allegheny
CLIPP, MD, Samuel W	Bucks
CLOEREN, Marianne	Students
CLOHECY, MD, Robert J	Allegheny
CLOSE, MD, Richard	Berks
CLOSKEY, MD, Gregory M	Montgomery
CLOSSON, MD, Edward W	Philadelphia
CLOUGH, MD, Douglas F	Allegheny
CLOUGHERTY, MD, Patrick W	Allegheny
CLUTZ, MD, Paul A	Franklin
CLYMAN, MD, Byron	Montgomery
CLYMER, MD, Robert H	Berks
COADY, MD, Paul M	Philadelphia
COATES JR, MD, John B	Chester
COBB, MD, Blaine W	Bradford
COBB, MD, Charles F	Allegheny
COBERN, MD, Charles B	Cambria
COBERT, MD, Howard S	Philadelphia
COBETTO, MD, Bernard H	Westmoreland
COBLENTZ, MD, Robert H	Allegheny
COCHRAN, MD, Bryce C	Jefferson
COCHRAN, MD, James F	Northampton
COCHRAN, MD, Terence A	Lackawanna
COCHRAN, MD, William C	Montgomery
COFF, MD, Philip M	Bucks
COFFEY, MD, Jesse O	Delaware
COFFEY, MD, William F	Philadelphia
COFFMAN, MD, Kaohlin M	Lycoming
COHEN, MD, Allan M	Chester
COHEN, MD, Archibald C	Butler
COHEN, MD, Arnold W	Philadelphia
COHEN, MD, Barbara E	Philadelphia
COHEN, MD, Bernard I	Allegheny
COHEN, MD, Bruce A	Berks
COHEN, MD, David J	Philadelphia
COHEN, MD, David L	York
COHEN, MD, Donald L	Mercer
COHEN, MD, Edwin E	Lycoming
COHEN, MD, Erwin A	Philadelphia
COHEN, MD, H Elliott	Philadelphia
COHEN, MD, H Emmanuel	Philadelphia
COHEN, MD, Harry W	Philadelphia
COHEN, MD, Ira J K	Allegheny
COHEN, MD, Isadore S	Philadelphia
COHEN, MD, J Stanley	Philadelphia
COHEN, MD, Jacob J	Philadelphia
COHEN, MD, Kenneth D	Philadelphia
COHEN, MD, Larry K	Allegheny
COHEN, MD, Leonard M	Allegheny
COHEN, MD, Manfred L	Allegheny
COHEN, MD, Martin A	Bucks
COHEN, MD, Merrill A	York
COHEN, MD, Merton E	Northampton
COHEN, MD, Meyer A	Philadelphia
COHEN, MD, Michael M	Philadelphia
COHEN, MD, Milton H	Mifflin/Juniata
COHEN, MD, Milton H	York
COHEN, MD, Norman F	Allegheny
COHEN, MD, Norman F	Philadelphia
COHEN, MD, Norman N	Philadelphia
COHEN, MD, Pamela E	Philadelphia
COHEN, MD, Paul A G	Philadelphia
COHEN, MD, Peter Z	Allegheny
COHEN, MD, Raphael M	Philadelphia
COHEN, MD, Robert	Bradford
COHEN, MD, Robert A	Westmoreland
COHEN, MD, Robert M	Philadelphia
COHEN, MD, Robert V	Philadelphia
COHEN, MD, Rona S	Philadelphia
COHEN, MD, Samuel	Indiana
COHEN, MD, Samuel F	Montgomery
COHEN, MD, Sarle H	Philadelphia
COHEN, MD, Sherwood V	Philadelphia
COHEN, MD, Stanley N	Philadelphia
COHEN, MD, Theodore B	Philadelphia
COHEN, MD, Tom	Luzerne
COHEN, MD, William W	Erie
COHLER, MD, Alan	Montgomery
COHN, MD, Burton H	Dauphin
COHN, MD, C Harold	Berks
COHN, MD, Edwin M	Philadelphia
COHN, MD, Gerald H	Montour
COHN, MD, Herbert E	Philadelphia
COHN, MD, John R	Philadelphia
COHN, MD, Ronald E	Allegheny
COLAIACO, MD, Victor I	Mercer
COLANCECCO, MD, Joseph P	Montour
COLANTONI, MD, William	Washington
COLASANTE, MD, Anthony D	Northampton
COLATRELLA, MD, Anthony M	Allegheny
COLAVINCENZO, MD, John W	Beaver
COLBERG, MD, James E	Philadelphia
COLBURN JR, MD, Harold L	Philadelphia
COLCHER, MD, Irving S	Montgomery
COLCHER, MD, Robert E	Montgomery
COLDREN, MD, Robert L	Dauphin
COLE, MD, Charles E	Allegheny
COLE, MD, Charles E	Lycoming
COLE, MD, Daniel J	Allegheny
COLE, MD, Dennis G	Erie
COLE, MD, Jack E	Northampton
COLE, MD, James M	Montour
COLE, MD, K Niki	Philadelphia
COLE, MD, Richard A	Erie
COLE, MD, Sherwood A	Dauphin
COLE EXEC, MD, Richard S	Westmoreland
COLEMAN, MD, Donald K	Northampton
COLEMAN, MD, Enid	Philadelphia
COLEMAN, MD, Ernest H	Centre
COLEMAN, MD, Linda L	Montour
COLEMAN, MD, Marcia J	Philadelphia
COLEMAN, MD, Thomas H	Lackawanna
COLEMAN JR, MD, Ernest H	Dauphin
COLETTA, MD, Anthony V	Philadelphia
COLETTA, MD, Daniel J	Bucks
COLLER, MD, Daniel H	Dauphin
COLLEY, MD, Alfred L	Philadelphia
COLLEY, MD, Arthur T	Montour
COLLEY, MD, John L	Allegheny
COLLINS, MD, Clyde A	Lackawanna
COLLINS, MD, Lawrence A	Allegheny
COLLINS, MD, Leonard R	Lycoming
COLLINS JR, MD, James A	Montour
COLLINS JR, MD, Richard F	Allegheny
COLLURA, MD, Paul T	Lancaster
COLMENAR, MD, Antonio B	Philadelphia
COLOMBO, MD, James L	Delaware
COLOMEDA, MD, Regio S	Montgomery
COLOSI, MD, Nicholas A	Montgomery
COLTMAN, MD, Arthur B	Philadelphia
COLTON, MD, Nathan H	Philadelphia
COLTON 5TH, MD, Sabin W	Montgomery
COLVIN, MD, Victor G	Bedford
COMBER, Paul G	Students
COMER, MD, Nathan L	Philadelphia
COMEROTA, MD, Anthony J	Philadelphia
COMESS, MD, Raymond R	Berks
COMISKEY, DO, Walter M	Philadelphia
COMSTOCK, MD, Lloyd K	Allegheny
CONAHAN, MD, Bernardin Q	Bucks
CONAHAN, MD, Thomas J	Luzerne
CONAHAN JR, MD, Joseph B	Monroe
CONAWAY, MD, Bruce E	Allegheny
CONCILUS, MD, Frank	Allegheny
CONDON, MD, Robert H	Delaware
CONDRON, MD, Brian P	Lancaster
CONE, MD, Alexander S	Allegheny
CONGEDO, MD, Carol Z	Allegheny
CONKLIN, MD, James E	Allegheny
CONKLIN, MD, Stanley D	Bradford
CONKLIN, MD, William T	Allegheny
CONLIN, MD, Edward F	Mercer
CONLY, MD, Frank L	Clinton
CONN, MD, Frank W	Bedford
CONN, MD, William V	Allegheny
CONNAUGHTON, MD, James F	Chester
CONNAUGHTON, MD, Patrick N	Lancaster
CONNELL, MD, Janet T	Chester
CONNELLY, MD, Jehue R	Fayette
CONNELLY, MD, Michael E	Mercer
CONNER, MD, Gary J	Allegheny
CONNER, MD, George H	Lebanon
CONNER, MD, J Hubert	Delaware
CONNER, MD, Kenneth B	Dauphin
CONNERTON, MD, George E	Berks
CONNOLE, MD, John F	Blair
CONNOLLY, MD, David P	Allegheny
CONNOLLY, MD, Steven M	Allegheny
CONNOLLY, DO, William S	Schuylkill
CONNOLLY JR, MD, John M	Bucks
CONNOR, DO, Janetta V	Philadelphia
CONNOR, DO, Joseph P	Philadelphia
CONNOR, MD, Robert W	Montgomery
CONNOR, MD, Susan A	Clarion
CONNORS, MD, Charles F	Lackawanna
CONNORS JR, MD, Earl K	Bucks
CONRAD, MD, Donald C	Dauphin
CONRAD, MD, James L	Bucks
CONRAD, MD, Joseph E	Schuylkill
CONRAD, MD, Rebecca S	Philadelphia
CONRAD, MD, Wayne R	Lancaster
CONRADY, MD, William E	Beaver
CONROY, DO, James F	Philadelphia
CONROY, MD, John J	York
CONROY, MD, Joseph V	Philadelphia
CONSALVO, MD, John A	Luzerne
CONSTANTINE, MD, Jay J	Philadelphia
CONSTANTINO JR, MD, Abraham A	Allegheny
CONSTINE, MD, Ronald M	Crawford
CONTE, MD, Anthony A	Beaver
CONTE, MD, Robert R	Westmoreland
CONTRACTOR, MD, Farhad M	Allegheny
CONVERSE, MD, Joseph O	Dauphin
CONWAY, MD, Cyril F	Lycoming
COOK, MD, David R	Allegheny
COOK, MD, Donald H	Chester
COOK, Marilue M	Allegheny
COOK, MD, Ralph W	Fayette
COOK, MD, Randall C	Allegheny
COOK, MD, Richard A	Fayette
COOK, MD, Richard P	Bucks
COOK, MD, Steven P	Philadelphia
COOK, MD, William L	Delaware
COOK, MD, William R	Allegheny
COOK JR, MD, Richard T	Philadelphia
COOKE, MD, Nora	Cumberland
COOKE JR, MD, Alfred J	Lancaster
COOLER, MD, Stewart	Philadelphia
COOLIDGE, MD, William A	Tioga
COONEL, MD, Pauline	Philadelphia
COONEY, MD, Edward A	Luzerne
COOPER, MD, David J	Chester
COOPER, MD, David R	Luzerne
COOPER, MD, Donald R	Philadelphia
COOPER, MD, Edward I	Philadelphia
COOPER, MD, Edward S	Philadelphia
COOPER, MD, Emmett M	Lancaster
COOPER, MD, Harold B	Schuylkill
COOPER, MD, Harry S	Philadelphia
COOPER, MD, Helen C	Luzerne
COOPER, MD, Homi S	Erie
COOPER, Jane D	Students
COOPER, MD, Jean W	Philadelphia
COOPER, MD, Jeanne A	Allegheny
COOPER, MD, Jeffrey	Montgomery
COOPER, MD, Joseph D	Montour
COOPER, MD, Joseph E	Luzerne
COOPER, MD, Joseph H	Delaware
COOPER, MD, Kenneth L	Lycoming
COOPER, MD, Mark W	Philadelphia
COOPER, MD, Martin	Philadelphia
COOPER, MD, Max M	Philadelphia
COOPER, MD, Murray S	Montgomery
COOPER, MD, Stephen	Centre
COOPER, MD, William M	Allegheny
COOPER III, MD, Herbert K	Lancaster
COOPER JR, MD, E Newbold	Delaware
COOPER JR, MD, Herbert K	Lancaster
COOPER JR, MD, Paul N	Allegheny
COOPERMAN, MD, Jay S	Philadelphia
COOPERSTEIN, MD, Lawrence A	Allegheny
COOPERSTEIN, DO, Mark S	Lancaster
COOPEY, MD, Frederick D	Lebanon
COORAY, MD, Charles N	Allegheny
COPE, MD, Constantin	Philadelphia
COPE, MD, David A	Berks
COPE, MD, Donald I	Butler
COPE, MD, Edwin S	Carbon
COPE, MD, Frederick T	York
COPELAN, MD, Herbert W	Philadelphia
COPELAND, MD, Adrian D	Philadelphia
COPELAND, MD, Charles E	Allegheny
COPPERMAN, MD, Gertrude	Philadelphia
COPPES, MD, Charles D	Philadelphia
COPPOLINO, MD, John F	Philadelphia
COPPOLO, MD, Bernard L	Elk/Cameron
COPPOLO JR, MD, Bernard L	Indiana
COPPULA, MD, Robert J	Washington
COPPULA, MD, William F	Allegheny
CORAZZA, MD, Leo J	Luzerne
CORBA, MD, Joseph S	Allegheny
CORBET, MD, Roland H	Venango
CORBETT, MD, John M	Lawrence
CORCINO JR, MD, Baltazar L	Clearfield
CORCORAN, MD, Albert W	Allegheny
CORCORAN, MD, James	Mckean
CORCORAN, MD, John J	Lancaster
CORDAS, DO, Michael	Northumberland
CORDELL JR, Charles E	Students
CORDERO, MD, Edgar C	Allegheny
CORDERO, MD, Hermelinda	Luzerne
CORDOBA, MD, Diego R	Armstrong
COREN, MD, Gary S	Philadelphia
COREY, MD, Peter J	Luzerne
COREY, MD, Stephen H	Allegheny
CORFF, MD, Meyer	Philadelphia
CORMAN, MD, Lev A	Philadelphia
CORMAN, MD, Paul M	Centre
CORNELIUS, MD, Jack R	Allegheny
CORNES, MD, Cleon L	Allegheny
CORNFIELD, MD, Dennis B	Philadelphia
CORNISH, MD, James W	Montgomery
CORNMAN III, MD, Henry D	Montgomery
COROSO, MD, Joseph G	Allegheny
CORPUZ JR, MD, Marcelo B	Allegheny
CORRADO, MD, Gail C	Montgomery
CORRADO, MD, Michael L	Philadelphia
CORRADO, MD, Sandra H	Bucks
CORRADO JR, MD, Albert V	Allegheny
CORRADO JR, MD, Cataldo F	Fayette
CORRAL, MD, Celestino F	Allegheny
CORREA-MEYER, MD, Paulo M	Delaware
CORRIDON, MD, Erin M	Philadelphia
CORRIGAN, MD, Dominic F	Montgomery
CORRIGAN, MD, Lawrence F	Luzerne
CORSELLO, MD, Guy R	Allegheny
CORSELLO, MD, Whitney C	Allegheny
CORSON, Gail R	Students
CORSON, MD, Geoffrey A	Dauphin
CORSON, MD, Hampton P	Cambria
CORSON, MD, Joseph K	Philadelphia
CORSON, MD, Stephen L	Philadelphia
CORSON, MD, Thomas C	Columbia
CORTES JR, MD, Candido T	Crawford
CORTEZA, MD, Benjamin A	Columbia
CORTINOVIS, MD, Charles R	Washington
CORVASCE, MD, Joseph M	Philadelphia
CORWIN, MD, Douglas T	Washington
COSGROVE, MD, Ellen M	Delaware
COSSROW, MD, Joel I	Beaver
COSTA, MD, Jose M	Jefferson
COSTA, MD, Ronald E	Huntingdon
COSTA-GRECO, MD, Maria A	Allegheny
COSTANZA, MD, Agatha H	Northampton
COSTELLO, MD, Ralph M	Westmoreland
COSTLOW, MD, James S	Allegheny
COTLER, MD, Jerome M	Philadelphia
COTTER, MD, Ralph E	Allegheny
COTTINGTON, MD, Gordon M	Butler
COTTLE, MD, Betty L	Blair
COTTLE, MD, Harold R	Blair
COTTONE, MD, Benjamin J	Lackawanna
COTTRELL, MD, David C	Philadelphia
COUCH, MD, F Boyd	Westmoreland
COUCH, MD, James B	Philadelphia
COULTER, MD, Clinton R	Clarion
COURSIN, MD, David B	Lancaster
COURTNEY, MD, Drew E	Lebanon
COURTNEY, MD, William B	Westmoreland
COURY, MD, Linda F	Allegheny
COUSOUNIS, MD, Gerry T	Philadelphia
COVALLA, MD, John R	Clearfield
COVELL, MD, John B	Clinton
COVERDALE, MD, Edward J	Bucks
COVERDALE, MD, Paul J	Bucks
COVERDALE III, MD, Edward J	Bucks
COVEY, MD, John K	Centre
COWAN, MD, Daniel F	Philadelphia
COWAN, MD, Thomas W	Allegheny
COWEN, DO, Stephen P	Philadelphia
COWGER, MD, David	Clinton
COWITZ, MD, Bernard	Philadelphia
COWLEY, MD, Allen W	Dauphin
COX, MD, James L	Philadelphia
COX, MD, John B	Allegheny
COX, MD, Paul A	Cumberland
COX, MD, Ralph L	Fayette
COYLE, MD, John J	Luzerne
COYLE, MD, Patrick J	Philadelphia
COYLE, MD, Richard J	Philadelphia
COYLE, MD, Robert M	Allegheny
COYLE, MD, Sophie J	Allegheny
COYLE, MD, William A	Delaware
COYNE, MD, Richard J	Philadelphia
COYNE, MD, Veronica Z	Bucks
COZINE, MD, Richard A	Lycoming
COZZA JR, MD, Michael R	Beaver

COZZARELLI, MD, James D	Montgomery
CRAGO, MD, H Robert	Mercer
CRAIG, MD, Paul C	Berks
CRAIG, MD, Richard A	York
CRAIN, MD, Richard H	Beaver
CRAKE, MD, Roger F	Columbia
CRAM, MD, Robert H	Philadelphia
CRAMER, MD, Arnold J	Montgomery
CRAMP, MD, Lloyd L	Berks
CRAMTON, MD, David C	Luzerne
CRANDALL, MD, Theodore L	Allegheny
CRANDALL III, MD, Richard A	Lancaster
CRANE, MD, A Reynolds	Philadelphia
CRAPARO, MD, Thomas J	Lackawanna
CRAVETZ, MD, Howard	Montgomery
CRAWFORD, MD, Donald G	Dauphin
CRAWFORD, MD, George A	Franklin
CRAWFORD JR, MD, Ralph W	Blair
CREARY, MD, Paul J	Allegheny
CREASY, MD, George W	Dauphin
CREECH, MD, Richard H	Philadelphia
CREIGHTON, MD, Malcolm A	Dauphin
CREIGHTON JR, MD, Daniel K	Mifflin/Juniata
CRESSON, MD, Samuel L	Philadelphia
CRETEKOS, MD, Constantine J	Allegheny
CRETELLA, MD, Thomas S	Columbia
CRIBBS, MD, Richard M	Westmoreland
CRIDEN, MD, Louis E	Delaware
CRIDER, MD, Donald B	Blair
CRIEP, MD, Leo H	Allegheny
CRILL, MD, Norman C	Lancaster
CRIMM, MD, Allan L	Philadelphia
CRISPEN, MD, James F	Dauphin
CRISPEN, MD, John W	Adams
CRISPINO, MD, Charles M	Allegheny
CRIST, MD, Guy C	Dauphin
CRIST, MD, Henry S	Cumberland
CRISTOL, MD, David S	Philadelphia
CRISTOL, MD, James L	Philadelphia
CRISWELL, MD, Samuel W	Lehigh
CRITS, MD, Harry J	Montgomery
CRITTENDEN, MD, Donald W	Bucks
CRITTENDEN, MD, George B	Erie
CROCK, MD, Frederick W	Allegheny
CROCKETT, MD, Barbara A	Delaware
CROLEY, MD, James T	Schuylkill
CROLL, MD, Millard N	Philadelphia
CROMO, Sandra A	Students
CROMPTON, MD, Richard E	Luzerne
CRONIN, MD, Dennis W	Philadelphia
CRONKEY, MD, Joseph E	Lackawanna
CROSS, MD, Albert J	Lackawanna
CROSS, MD, Raquel	Erie
CROSS, MD, Robert L	Allegheny
CROSS JR, MD, Samuel	Armstrong
CROTEAU, MD, J Russell	Dauphin
CROTHERS, MD, W Gifford	Delaware
CROUSE, MD, George W	Westmoreland
CROVATTO, MD, Arthur C	York
CROWLEY, MD, Patricia A	Allegheny
CROYLE, MD, Ray W	Westmoreland
CROYLE EXEC, SEC, Mrs Luann	Armstrong
CROZIER, MD, Phyllis A	Allegheny
CRUCETTI, MD, James B	York
CRUCIANI, MD, Mark	Allegheny
CRUCIANI JR, MD, Dominick A	Lackawanna
CRUDO, MD, Chito M	Westmoreland
CRUFT, MD, George E	Philadelphia
CRUM, MD, George E	Allegheny
CRUMAY, MD, Hugh M	Dauphin
CRUMRINE, MD, Richard S	Beaver
CRUTCHER, MD, James E	Berks
CRUZ, MD, Alexander C	Montgomery
CRUZ, MD, Alice M	Greene
CRUZ, MD, Edgardo S	Lehigh
CRUZ, MD, Rogelio A	Erie
CRUZ, MD, Trinidad T	Greene
CRUZ JR, MD, Moises B	Potter
CRYER, MD, Theodore H	Franklin
CRYSTAL, MD, Harry	Berks
CRYSTLE, MD, C Deans	Lancaster
CSIKOS, MD, David A	Cambria
CSIR, MD, Floyd M	Erie
CUBE, MD, Henry M	Somerset
CUBLER, MD, Edward W	Schuylkill
CUCINOTTA, MD, Salvatore	Philadelphia
CUCKLER, MD, John M	Philadelphia
CUDDEBACK, MD, Thomas J	Allegheny
CUDDY, MD, Vincent D	Beaver
CUISON, MD, Navora G	Delaware
CUISON, MD, Sergio Q	Delaware
CULBERTSON, MD, Clayton E	Washington
CULF, MD, Norris K	Philadelphia
CULIG, MD, Carl A	Allegheny
CULLEN, MD, Esker W	Centre
CULLEN, MD, Milton L	Philadelphia
CULLEY, MD, Andrew W	Beaver
CULLINEY, MD, John J	Philadelphia
CULOTTA, MD, Dominic A	Bucks
CULP, MD, Robert T	Venango
CULYBA, MD, Michael J	Beaver
CUMMINGS, MD, Clarence W	Allegheny
CUMMINGS, Peter D	Students
CUMMINS III, MD, Claude E	Philadelphia
CUNNINGHAM, MD, J David	Montgomery
CUNNINGHAM, MD, James G	Allegheny
CUNNINGHAM, MD, John R	Erie
CUNNINGHAM, MD, Peter L	Northampton
CUNNINGHAM, MD, William L	Washington
CUPPLE, MD, Peter P	Lackawanna
CURANZY, MD, Raymond R	Lebanon
CURCI, MD, Joseph J	Bucks
CURCILLO, Paul G	Students
CURCIO, MD, Mary R	Philadelphia
CURCIO III, MD, Frederick D	Dauphin
CURLEY, MD, Henry E	Allegheny
CURRAN, MD, Marilyn R	Montgomery
CURRID, MD, Aideen M	Montour
CURRIE, MD, Philip W	Westmoreland
CURRIE, MD, Richard J	Philadelphia
CURRY, MD, Joseph L	Northampton
CURRY, MD, Samuel O	Dauphin
CURRY, MD, Thomas A	Schuylkill
CURRY JR, MD, William O	Montour
CURTIN, MD, Charles T	Lackawanna
CURTIN, MD, Eugene A	Lackawanna
CURTIN, MD, John J	Philadelphia
CURTIS, MD, Craig W	Beaver
CURTIS, MD, James L	Montour
CUSHING, MD, William J	Allegheny
CUSTER, MD, Richard P	Philadelphia
CUSTODIO, MD, Edgardo C	Lehigh
CUTLER, MD, Charles	Montgomery
CUTLER, MD, Irvin	Philadelphia
CUTLER, MD, Larry A	Montgomery
CUTLER, MD, Neil	Philadelphia
CUTLER, MD, Robert S	Chester
CUTRY, MD, Joseph J	Potter
CUTULY, MD, Eugene	Allegheny
CWIK, MD, John C	Cambria
CYMERMAN, MD, Frank R	Allegheny
CYNN, MD, Won S	Philadelphia
CYPHER, MD, Ronald L	Allegheny
CZARNECKI, MD, Casimir	Philadelphia
CZARNECKI, MD, Dorothy G	Philadelphia
CZARNECKI, MD, Nancy S	Philadelphia
CZWALINA, DO, Robert	Luzerne

D

DABB, MD, Richard W	York
DABBACK, MD, Dewitt T	Chester
DACOSTA, MD, Joao B	Allegheny
DACZKOWSKI, DO, Dolores V	Philadelphia
DADPARVAR, MD, Simin D	Philadelphia
DADVAND, MD, Mahmood	Philadelphia
DAFFNER, MD, Richard H	Allegheny
DAFTARY, MD, Sudhir R	Lawrence
DAGEN, MD, J Edward	Cumberland
DAGHESTANI, MD, Aiman N	Crawford
DAGOSTINO, MD, Frank J	Northampton
DAGOSTINO, MD, Valentino	Philadelphia
DAHMUS, MD, Robert R	Dauphin
DAIELLO, MD, David C	Berks
DAIL, MD, Eric M	Erie
DAILEY, MD, Edward G	Dauphin
DAILEY, MD, Ellen E	Erie
DAINIUS, MD, Alfonsas	Luzerne
DAIT, MD, Jose E	Carbon
DAITER, MD, Donald	Philadelphia
DAITER, Eric	Students
DAJANI, MD, Taher A	Armstrong
DAKIN, MD, Theodora P	Westmoreland
DALE, MD, Anthony D	Philadelphia
DALE, MD, H Thompson	Centre
DALE II, MD, Leonard E	Tioga
DALE JR, MD, Hiram T	Northampton
DALEY, MD, Marvin C	Lancaster
DALLABRIDA, MD, Marguerite R	Northumberland
DALONZO, MD, Walter A	Philadelphia
DALRYMPLE, MD, W Howard	Delaware
DALY, MD, Christopher J	Allegheny
DALY, MD, Christopher X	Philadelphia
DALY, MD, David G	Berks
DALY, MD, Jane	Lackawanna
DALY, MD, William J	Montgomery
DALY JR, MD, James F	Dauphin
DALY JR, MD, Michael J	Philadelphia
DALY JR, MD, Richard H	York
DAMANDA, MD, Christopher	Philadelphia
DAMATO, MD, Samuel L	Lancaster
DAMAZO, MD, Elpidio D	Beaver
DAMAZO, MD, Natividad S	Beaver
DAMESHEK, MD, H Lee	Allegheny
DAMIANO, MD, Robert E	Chester
DAMICO, Frank C	Allegheny
DAMJANOV, MD, Ivan	Philadelphia
DAMORE, MD, David L	Mercer
DAMSKER, MD, Jeffrey I	Philadelphia
DANAEE, MD, Nosratollah	Allegheny
DANCA, MD, Alfred F	Luzerne
DANDREA, MD, Linda M	Philadelphia
DANDREA, MD, Raymond L	Cambria
DANFORTH, MD, Nicholas	Montour
DANGELO, MD, Carl F	Lehigh
DANGELO, MD, George J	Erie
DANGELO, MD, Marc S	Philadelphia
DANGIO, MD, Giulio J	Philadelphia
DANIELE, MD, Joseph Q	Erie
DANIELS, MD, Dan	Jefferson
DANIELS, MD, Roger B	Philadelphia
DANIS, MD, Martha J	Philadelphia
DANISHANKO, MD, Albert G	Luzerne
DANKMYER, MD, Frederick L	Schuylkill
DANKO, MD, Eugene T	Allegheny
DANNEKER, MD, Dale A	Centre
DANNENBURG, MD, Arthur M	Philadelphia
DANOFF, MD, Barbara F	Philadelphia
DANOFF, MD, David M	Montgomery
DANOFF, MD, Mike	Allegheny
DANOWSKI, MD, Thaddeus S	Allegheny
DANTE, MD, Stephen J	Philadelphia
DANTINI JR, MD, Daniel C	Allegheny
DANTONIO, MD, James A	Allegheny
DANYO, MD, J Joseph	York
DANZI, MD, Joseph T	Bradford
DANZIS, DO, Jeffrey J	Bucks
DAQUILANTE, Debra A	Students
DARKES, MD, William	Schuylkill
DARNALL, MD, Jeffrey T	Delaware
DARNELL, MD, Richard I	Bucks
DARON, MD, Andrew M	Centre
DAROWISH, DO, Charles E	Dauphin
DAS, MD, Arunava	Greene
DASCHER JR, MD, John J	Montgomery
DASHE, MD, Myer M	Berks
DASTUR, MD, Khurshed J	Allegheny
DATTA, MD, Bhupinder S	Allegheny
DATTA, MD, Tapan D	Westmoreland
DATTILO, MD, James T	Allegheny
DAUE JR, MD, Edwin O	Dauphin
DAULER, MD, Thomas P	Centre
DAURIA, MD, Thomas M	Fayette
DAVE, MD, Harish R	Montour
DAVENPORT, MD, Arthur B	Wyoming
DAVIDES, MD, Kyriakos C	Allegheny
DAVIDSON, DO, James P	Clearfield
DAVIDSON, MD, Jay H	Philadelphia
DAVIDSON, MD, Paul R	Lancaster
DAVIDSON, MD, Richard S	Philadelphia
DAVIDSON, MD, Steven J	Philadelphia
DAVIDSON JR, MD, William R	Lebanon
DAVIE, MD, Frank M	Westmoreland
DAVIES, MD, Barbara L	Philadelphia
DAVIES, MD, Thomas E	Tioga
DAVIS, MD, Allan S	Lancaster
DAVIS, MD, C Nelson	Philadelphia
DAVIS, MD, Daniel T	Luzerne
DAVIS, MD, Dennis	Washington
DAVIS, MD, Donald D	Allegheny
DAVIS, MD, Duane E	Montour
DAVIS, MD, Earl Clayton	York
DAVIS, MD, Earle R	Allegheny
DAVIS, MD, Edward W	Montgomery
DAVIS, MD, George A	Delaware
DAVIS, MD, George B	Luzerne
DAVIS, MD, H Robert	Cumberland
DAVIS, MD, Harold J	Lackawanna
DAVIS, MD, Harriet J	Bucks
DAVIS, MD, Irene B	Lancaster
DAVIS, MD, J Mostyn	Montour
DAVIS, MD, James H	York
DAVIS, MD, James K	Cambria
DAVIS, MD, John C	Crawford
DAVIS, MD, John G	Allegheny
DAVIS, MD, John W	Philadelphia
DAVIS, MD, Murray C	Tioga
DAVIS, MD, Paul K	Dauphin
DAVIS, MD, Raymond C	Susquehanna
DAVIS, MD, Richard A	Philadelphia
DAVIS, MD, Robert A	Bucks
DAVIS, MD, Robert E	Allegheny
DAVIS, MD, Robert M	York
DAVIS, MD, Sidney	Union
DAVIS, MD, Stephen J	Dauphin
DAVIS, MD, Stuart M	Tioga
DAVIS, MD, Thomas G	Philadelphia
DAVIS, MD, Thomas P	Franklin
DAVIS, MD, Thomas S	Dauphin
DAVIS, MD, Toye G	Chester
DAVIS, MD, William B	Berks
DAVIS, MD, William F	Wayne/Pike
DAVIS, MD, William L	Franklin
DAVIS, MD, William S	Dauphin
DAVIS JR, MD, Edward T	Beaver
DAVIS JR, MD, Robert V	Lackawanna
DAVIS JR, MD, Rollin V	Allegheny
DAVISON, MD, Francis W	Montour
DAVISON, MD, William R	Cambria
DAVITCH, MD, Leonard S	Philadelphia
DAVNE, MD, Sanford H	Philadelphia
DAVOLI, MD, Robert L	Westmoreland
DAW, MD, William J	Luzerne
DAWGERT, MD, F Dennis	Lackawanna
DAWSON, MD, Reese E	Allegheny
DAWSON, MD, William N	Allegheny
DAY, MD, James H	Allegheny
DAY JR, MD, Richard W	Allegheny
DAY JR, MD, Robert E	Montgomery
DCRUZ, MD, Joseph F	Blair
DE, MD, Nirmal K	Philadelphia
DEALVAREZ, MD, Russell R	Montgomery
DEAN, MD, J Christine	Allegheny
DEAN, James L	Students
DEAN, MD, Randy M	Allegheny
DEAN, MD, Robert J	Allegheny
DEAN, MD, Vernon E	Crawford
DEANTONIO, MD, Angela M	Montour
DEARDORFF, MD, Charles L	Lancaster
DEARMITT, Don A	Allegheny
DEAS, MD, Thomas C	Philadelphia
DEBENEDICTIS, MD, Kenneth J	Berks
DEBERARDINIS, MD, Camillo T	Philadelphia
DEBOER, MD, John L	Monroe
DEBONIS, MD, Charles S	Luzerne
DEBONIS-O REILLY, MD, Maryellen	Westmoreland
DECANDIS, Francis X	Students
DECARO, MD, Joseph A	Delaware
DECASPERIS, MD, Anthony J	Philadelphia
DECASTRO, MD, Nieves D	Philadelphia
DECESARE, DO, Raymond C	Monroe
DECHERNEY, MD, William A	Philadelphia
DECHTER, MD, Joseph M	Allegheny
DECKER, MD, John P	Philadelphia
DECKER, MD, Peter G	Luzerne
DECKER, MD, Richard L	Erie
DECKER, MD, Steven E	Montgomery
DECOLLI, MD, Joseph A	Chester
DECOSMO, MD, Vincent J	Westmoreland
DECURTIS, MD, George M	Luzerne
DEDHIA, MD, Champak	Luzerne
DEE, MD, Cecilio C	Mckean
DEE, MD, William F	Allegheny
DEEB, MD, George M	Philadelphia
DEEB, MD, Ramon J	Lehigh
DEES-PORCH, MD, Frances	Delaware
DEFRANCISCO, MD, Lance C	Blair
DEFRANCISCO, MD, Mary E	Montgomery
DEFRANCO, MD, Joseph M	Erie
DEFRANK, MD, Frank N	Monroe
DEFREITAS, MD, Junior	Delaware
DEGENNARO, MD, Louis P	Lackawanna
DEGENNARO, MD, Patrick J	Luzerne
DEGREEN, MD, Hyatt P	Lancaster
DEGREGORIO, MD, Nicholas	Allegheny
DEGREGORY, DO, Thomas R	Westmoreland
DEGROAT, MD, Thomas S	Philadelphia
DEGROOF, MD, Ellen P L	Bucks
DEGUZMAN, MD, Brigida	Philadelphia
DEGUZMAN, MD, Rudolfo L	Berks
DEHAAS, MD, David R	Washington
DEHART, MD, David A	Allegheny
DEHORATIUS, MD, Raphael F	Philadelphia
DEHORATIUS, MD, Raphael J	Philadelphia
DEIBERT, MD, David C	Berks
DEIBERT, MD, Edward B	Northampton
DEICHERT, MD, Robert G	Monroe
DEILY, MD, Raymond E	Northampton
DEIMEL, MD, Joseph F	Erie
DEIN, MD, Robert A	Philadelphia
DEININGER, MD, Arthur G	Crawford
DEININGER, MD, John T	Philadelphia
DEISHER, MD, Samuel W	York
DEITCH, MD, Bernard	Philadelphia
DEITCH, MD, Marc W	Philadelphia
DEITRICK, MD, John E	Montour
DEITRICK, MD, Richard E	Allegheny
DEITRICK III, MD, George A	Philadelphia
DEITRICK JR, MD, George A	Northumberland
DEITZ III, MD, George W	Montgomery
DEITZLER, MD, Margaret M	Philadelphia
DEJESUS, MD, Robert	Westmoreland
DEJESUS JR, MD, Roman Y	Beaver
DEJOSEPH, MD, Robert L	Luzerne
DEKKER, MD, Andrew	Allegheny
DEKONING, MD, Johannes L	Blair
DEKRET, MD, Jeffrey J	Philadelphia
DEKRUIF, MD, Hendrik	Crawford
DELACRUZ, MD, Apolinar D	Montgomery
DELACRUZ, MD, Silvestre S	Dauphin
DELAFUENTE, MD, Carlos F	Dauphin
DELAGO, Cynthia W	Students
DELAITES, MD, Loretta M	Delaware
DELANEY, MD, James H	Erie
DELAPLANE, MD, James M	Philadelphia
DELASALAS, MD, Ernesto M	Bedford
DELATORRE, MD, Henry G	Jefferson
DELAURENTIS, MD, Dominic A	Philadelphia
DELAVEGA, MD, Sofronio B	Allegheny
DELCASTILLO, MD, Juan J	Northumberland
DELCONTE, MD, Anthony	Allegheny
DELEHANTY, MD, Thomas J	Lackawanna
DELENICK, MD, Peter J	Berks
DELEO, MD, Caesar A	Lackawanna
DELEO, MD, Nicholas V	Lackawanna
DELEON, MD, Manuel R	Allegheny
DELERME, MD, Augusto N	Blair
DELGADO, MD, Juan F	Northumberland
DELGADO, MD, Tomas E	Philadelphia
DELGATTO, MD, Louis J	Columbia
DELGRIPPO, MD, Gerard A	Clinton
DELGRIPPO JR, Gerard A	Students
DELGUERCIO, MD, Edmund T	Delaware
DELICH, MD, John P	Elk/Cameron
DELISSER, Horace M	Students
DELLA-ROSA JR, MD, John J	Luzerne
DELLINGER, MD, Woodrow S	York
DELOGLOS, MD, Gust	Allegheny
DELOLLIS, MD, Michael V	Allegheny
DELONE JR, MD, Charles A	Dauphin
DELONE JR, MD, Francis X	Delaware
DELONG, MD, Brian S	Dauphin
DELONG, MD, Philip L	Bucks
DELONG, MD, Stephen R	Allegheny
DELONG JR, MD, William G	Philadelphia
DELORENZO JR, MD, Donald P	Franklin
DELP, MD, Charles W	Schuylkill
DELP, MD, Richard U	Columbia
DELP, MD, William T	York
DELP JR, MD, Charles W	Montgomery
DELROSARIO, MD, Vivencio G	Dauphin
DELROSSI, MD, Anthony J	Philadelphia
DELSERONE, MD, Eugene W	Allegheny
DELUCA, MD, Jeffrey V	Philadelphia
DELUCIA, MD, Frank A	Philadelphia
DELVECCHIO, MD, Leonard M	Berks
DELVECCHIO JR, MD, Leonard M	Mifflin/Juniata

DEMARCO, MD, Carlo M Philadelphia
DEMARCO, MD, James C Delaware
DEMARCO, MD, John J Erie
DEMARCO, MD, Joseph F Montgomery
DEMARCO, MD, Salvatore G Northampton
DEMARIA JR, MD, Peter A Philadelphia
DEMASI, MD, Leon G Philadelphia
DEMASI, MD, Pantaleone Philadelphia
DEMASI, MD, Rocco J York
DEMATTEIS, MD, James A Erie
DEMBY, MD, Dennis M Butler
DEMEDIO, MD, Gabriel A Allegheny
DEMEDIUK, MD, Oksana M Philadelphia
DEMEZZA, MD, Angelo Westmoreland
DEMICHELE, MD, Joseph Philadelphia
DEMILIO, MD, Terrance A Westmoreland
DEMITZ, MD, Charles G Dauphin
DEMJANENKO, MD, Paul Allegheny
DEMKO, MD, Joseph N Lackawanna
DEMOPOULOS, MD, James T Philadelphia
DEMOS, MD, Jack Allegheny
DEMOURA, MD, Jamilo B Philadelphia
DEMPSEY, MD, Eugene C Philadelphia
DEMPSEY, MD, James G Lackawanna
DEMPSHER, MD, John Chester
DEMUTH, MD, Cynthia T Dauphin
DEMUTH JR, MD, William E Cumberland
DENBY, MD, Robert A Berks
DENCH JR, MD, Edward H Centre
DENDE, DO, Paul F Lackawanna
DENGLER, MD, Ernest H Berks
DENIZARD, MD, Carl E Philadelphia
DENLINGER, MD, John K Lancaster
DENLINGER, MD, Lee E Venango
DENNEHY, MD, John J Montour
DENNIS, MD, James B Columbia
DENT, MD, Thomas L Montgomery
DENTON, MD, Clarence Philadelphia
DENVER, MD, Stanley D Allegheny
DEOCERA, MD, Rodolfo M Bucks
DEOL, MD, Jasbir S Northampton
DEPACE, MD, Nicholas L Philadelphia
DEPAOLI, MD, Rosemary T Montour
DEPAULA, MD, Carl J Philadelphia
DEPRISCO, DO, John Philadelphia
DEPROPHETIS, MD, Rocco I Delaware
DEQUEVEDO, MD, Robert F Monroe
DERASSE, MD, Alain R Northampton
DERASSE, MD, Judith R Northampton
DERATZOU, Benjamin Allegheny
DERDEL, MD, Jerome D Centre
DERENZO, MD, Aurelio G Philadelphia
DEREWITZ, MD, Daniel L York
DERHAM, MD, Robert J Philadelphia
DERIENZO, MD, Umberto A Washington
DERIVAS, MD, Carmela F Montgomery
DERKRIKORIAN, MD, Hagop L Delaware
DERMAN, Seth G Allegheny
DERR, MD, Craig A Berks
DERR, MD, Frederick S Union
DERR, MD, Russell H Lancaster
DERRICK, MD, Bruce M Bucks
DERSH, MD, Jerome Berks
DERSHAW, MD, Bruce B Bucks
DERSHAW, MD, Samuel Philadelphia
DERSTINE, MD, Ralph L Montgomery
DERVAN, MD, John P Philadelphia
DESAI, MD, Ajit M Philadelphia
DESAI, MD, Anil G Philadelphia
DESAI, MD, Ansuya M Montgomery
DESAI, MD, Arundev D Lackawanna
DESAI, MD, Arvind D Lackawanna
DESAI, MD, Bharati P Westmoreland
DESAI, MD, Jitendra M Allegheny
DESAI, MD, Kashmira A Lackawanna
DESAI, MD, Kiritkumar T Philadelphia
DESAI, MD, Meena B Lackawanna
DESAI, MD, Mohan G Montgomery
DESAI, MD, Praful V Westmoreland
DESAI, MD, Saryu J Allegheny
DESAI, MD, Shirishkumar B Greene
DESANCTIS JR, MD, Joseph J Berks
DESANTES, MD, Frank A Blair
DESANTIS, MD, Joseph G Philadelphia
DESANTIS, MD, Peter L Mercer
DESANTOS, MD, Marcelino A Bucks
DESHMUKH, MD, Narayan Bradford
DESHPANDE, MD, Asha S Warren
DESHPANDE, MD, Sharadchandra Erie
DESHPANDE, MD, Vilas K Lehigh
DESIATO, MD, Nicola Philadelphia
DESIMONE, MD, Gregory G Delaware
DESIMONE, MD, John S Westmoreland
DESIO, MD, Felix J Bradford
DESJARDINS, MD, George P Berks
DESJARDINS JR, MD, George P Berks
DESMOND, MD, Robert E Philadelphia
DESPREZ, MD, Renkert J Philadelphia
DESSABLES, Daniel R Students
DESSEN, MD, Edgar L Luzerne
DESSEN, MD, Edward Philadelphia
DETHOFF, MD, John C Berks
DETRE, MD, Thomas Allegheny
DETUERK, MD, John J Philadelphia
DETULLIO, MD, Anthony E Philadelphia
DETWEILER EXEC, SEC, John S Bucks
DEUTSCH, MD, Joel Philadelphia
DEUTSCH, MD, Melvin Allegheny
DEUTSCH JR, MD, E Thomas Chester
DEVAN, MD, W Todd York
DEVANI, MD, Shyamsunder H Carbon
DEVENNEY, MD, John E Montgomery
DEVINE, MD, Jean K Montgomery
DEVINE, MD, Michael F Montgomery
DEVINE, MD, Peter J Philadelphia
DEVINE, MD, Terence M Bradford
DEVINEY, MD, John P Montgomery
DEVITA, MD, Dennis M Mifflin/Juniata
DEVITA, MD, Michael L Mifflin/Juniata
DEVITTORIO, MD, Armond A Jefferson
DEVLIN, MD, Albert E Jefferson
DEVLIN, MD, Joseph M York
DEVLIN, MD, Joseph T Philadelphia
DEVLIN, MD, Michael F Luzerne
DEVRIES, MD, Egbert J Allegheny
DEVRIES, MD, Jan R Somerset
DEWAR, MD, William R Wayne/Pike
DEWAR III, MD, William R Wayne/Pike
DEWIS, MD, Lester S Chester
DEX, MD, Walter J Lehigh
DEYOUNG, MD, Edward M Philadelphia
DHAGAT, MD, Satishchandra Beaver
DHALIWAL, MD, Iqubal S Philadelphia
DHALIWAL, MD, Ranjit S Erie
DHAR, MD, Jyotsna K Mifflin/Juniata
DHAWAN, MD, Neelam Allegheny
DHAWAN, MD, Ram L Allegheny
DHAWER, MD, Virender P S Cambria
DHEEN, MD, Mohamed H R Lawrence
DI CROCE, MD, Joseph N Allegheny
DIAKIW, MD, John Lackawanna
DIAMANTONI, MD, Stephen G Lancaster
DIAMOND, MD, B Franklin Montgomery
DIAMOND, MD, Daniel L Allegheny
DIAMOND, MD, Mark Allegheny
DIAMOND, MD, Sidney J Delaware
DIAZ, MD, Filadelfo T Montgomery
DIAZ, MD, Floriel P Carbon
DIBAGNO, MD, Geno J Westmoreland
DIBELLO, MD, Angelo M Philadelphia
DIBERT, MD, Lawrence W Blair
DICKENS, MD, Helen O Philadelphia
DICKERMAN, MD, Diane E Philadelphia
DICKEY, MD, Robert F Montour
DICKINSON, Kim Students
DICKINSON, MD, Peter A Allegheny
DICKSON, MD, Glenn S Philadelphia
DICKSON, MD, Robert L Philadelphia
DICKSON JR, MD, Thomas B Lehigh
DICKSTEIN, MD, Benjamin Philadelphia
DICOLA, MD, Nancy M Allegheny
DICUCCIO, MD, Nicholas W Clinton
DICUCCIO, MD, William A Butler
DIDDLE, MD, Kenneth W Westmoreland
DIDONATO, MD, Richard R Huntingdon
DIEHL, MD, Daniel L Lancaster
DIEHL, MD, William H Lebanon
DIEN, MD, Philip Allegheny
DIENER, MD, Ian L Montgomery
DIENHART, MD, Karl J Bradford
DIETEMAN, MD, David F Erie
DIETRICH, MD, C Wallace Allegheny
DIETRICH, DO, Leonard M Berks
DIETRICH, MD, Warren C Northampton
DIETRICH, MD, William S Dauphin
DIETRICK, MD, Ronald A Blair
DIETTINGER, MD, Frank G Armstrong
DIETZEN, Diane L Students
DIEZ, MD, Charles M Allegheny
DIGERGORIO, MD, Guerino J Chester
DIGIACOMO, MD, Oscar P Philadelphia
DIGIACOMO, MD, Paul R Lebanon
DIGIACOMO JR, MD, Philip J Montgomery
DIGILIO, MD, Victor A Philadelphia
DIGIOVANNI, MD, Anthony J Delaware
DIGIOVANNI, MD, Robert J Delaware
DIGIOVANNI, MD, Vincent J Luzerne
DIILIO, MD, Richard P Allegheny
DIIORIO, MD, Emil J Northampton
DILCHER, MD, Robert H Lehigh
DILEO, MD, Dominic W Fayette
DILIBERTO, DO, Thomas A Delaware
DILLINGER, MD, Ellen M Allegheny
DILLON, MD, Daniel J Allegheny
DILLON, MD, Richard S Montgomery
DIMAGGIO, MD, Olivia T Philadelphia
DIMARCO, MD, Ross F Allegheny
DIMEDIO, MD, Joseph A Delaware
DIMICK, MD, Dean F Lehigh
DIMILILER, MD, Ismail Northumberland
DIMINO, DO, Joseph M Montgomery
DIMITSOPULOS, MD, Dimitri Allegheny
DIMUN, MD, Michael F Allegheny
DINATTI III, Louis A Allegheny
DINEEN, MD, Francis A Allegheny
DINICOLA, MD, Arthur N Schuylkill
DINMAN, MD, Bertram D Allegheny
DINON, MD, Louis R Philadelphia
DINSMORE, MD, Harry H Jefferson
DINUBILE, MD, Nicholas A Philadelphia
DINULOS, MD, Baltazar T Lebanon
DION, MD, Harry S Philadelphia
DIORIO, MD, James P Luzerne
DIORIO, MD, Norina M Luzerne
DIPASQUALE, DO, Urban D Montgomery
DIRENZO, MD, Dennis P Berks
DIRIENZO, MD, Enrico J Bucks
DIRNBERGER, DO, Thomas Schuylkill
DIROCCO, MD, Vincent P Philadelphia
DISALVO, MD, Barbara A Northampton
DISALVO, MD, Eugene I Northampton
DISHART, MD, Paul W Allegheny
DISICK, MD, Solomon Centre
DISILVESTRO, MD, Helen E Philadelphia
DISILVESTRO JR, MD, John M A Philadelphia
DISILVIO, MD, Thomas V Lackawanna
DISTEFANO, MD, Berardino Erie
DISTEFANO, MD, Grimaldo C Philadelphia
DITLOW JR, MD, Richard J Bradford
DITMARS, MD, Douglas D Northampton
DITTMAN, MD, Thomas H Luzerne
DITTMAR, MD, Stuart W Franklin
DITTRICH, DO, Richard J Philadelphia
DITUNNO, MD, John F Philadelphia
DIWAN, MD, Kanta Delaware
DIX, David G Students
DIX JR, MD, Robert C Union
DIXIT, MD, Niranjan D Fayette
DIXON, MD, Harold L Philadelphia
DIXON, MD, Richard H Centre
DIXON, MD, Robert E Mifflin/Juniata
DIZON, MD, Gaudencio S Carbon
DJERASSI, MD, Isaac Philadelphia
DLIN, MD, Barney M Philadelphia
DLUTOWSKI, MD, Bernard J Philadelphia
DLUZANSKY, MD, James J Blair
DOAN, MD, Huynh Trieu Philadelphia
DOBISH, MD, Michael J York
DOBKIN, MD, Larry A Allegheny
DOBLE II, MD, Henry P Mercer
DOBLER, MD, James C Allegheny
DOBLER, MD, Lee C Allegheny
DOBOSH, MD, George A Northampton
DOBROTA, MD, John S Bucks
DOCKTOR, MD, John W York
DODD, MD, Stephen I Mifflin/Juniata
DODDS, MD, Harold T Delaware
DODGE, MD, Herbert C Philadelphia
DOE, MD, Robert G Lancaster
DOEBLER, MD, Robert W Allegheny
DOEFF, MD, Jan W Montgomery
DOELL, MD, Robert J Allegheny
DOENECKE, MD, Arthur L Lancaster
DOENLEN III, MD, Henry A Philadelphia
DOERFLER JR, MD, Frederick B Allegheny
DOFT, MD, Bernard H Allegheny
DOHERTY, DO, John M Delaware
DOHERTY, MD, Joseph C Westmoreland
DOHERTY JR, MD, Henry J Montgomery
DOHERTY JR, MD, John H Lackawanna
DOHERTY SR, MD, John H Lackawanna
DOKKO, Yoni Allegheny
DOLAN III, MD, James J Clinton
DOLFMAN, MD, Victor Philadelphia
DOLINSKAS, MD, Carol A Philadelphia
DOLL JR, MD, Robert B Lehigh
DOLPHIN, MD, John M Philadelphia
DOLPHIN, MD, Murray Luzerne
DOLSKY, MD, Richard L Montgomery
DOMALESKI, MD, Alfred F Potter
DOMAN, MD, Robert J Delaware
DOMANSKI, MD, Robert E Philadelphia
DOMBKOSKI, DO, Frank P Crawford
DOMESEK, MD, James M Montgomery
DOMINGO, MD, Orville H Delaware
DOMJANCIC, MD, John T Beaver
DOMON, MD, Charles M Philadelphia
DOMZALSKI, Francis J Students
DONAHOE, MD, Michael T Franklin
DONAHOO, MD, James S Philadelphia
DONAHUE, MD, John R Montgomery
DONALD, MD, Delmar J Montgomery
DONALDSON, MD, David H Allegheny
DONALDSON, MD, James B Philadelphia
DONALDSON, MD, James O Butler
DONALDSON, MD, William F Allegheny
DONAN, MD, Anderson W Mercer
DONATO, MD, Robert A Philadelphia
DONCASTER, MD, Richard M Westmoreland
DONEKER, MD, Thomas G Northampton
DONER, DO, Ivan A Philadelphia
DONG, MD, Mai-Li Allegheny
DONLY, MD, Donovan L Berks
DONNELLY III, MD, Edward J Allegheny
DONNELLY JR, MD, Joseph C Berks
DONNER, MD, Marda E Philadelphia
DONNER, MD, William T Montgomery
DONOFRIO, MD, Robert J Allegheny
DONOFRIO, MD, Romeo R Chester
DONOVAN, MD, Byron L Westmoreland
DONOVAN, MD, Francis C Allegheny
DONOVAN, MD, J Ward Dauphin
DONOVAN, MD, John J Allegheny
DONOVAN, MD, Robert J Allegheny
DONOVAN, MD, Robert J Philadelphia
DONOVAN, MD, Robert S Berks
DONROVICH, MD, Paul J Cambria
DOO, MD, Gerald K Adams
DORASAVAGE, MD, William C Schuylkill
DORAZIO, MD, Dominick J Lancaster
DORAZIO, MD, Edward A Philadelphia
DORAZIO, MD, Nicholas J Chester
DORAZIO, DO, Ronald J Delaware
DORFMAN, MD, Alan M Philadelphia
DORFMAN, MD, Murray L Delaware
DORIAN, MD, Alan L Montgomery
DORIO, MD, Raymond J Philadelphia
DORKO, MD, Carl J Dauphin
DORMAN, MD, Franklin L Allegheny
DORMAN, MD, Gordon Philadelphia
DORMAN, MD, Sanford A Northampton
DORMANS, MD, Adrian A Luzerne
DORNENBURG, MD, James R Allegheny
DORNSTEIN, MD, Perry I Philadelphia
DORSCH JR, MD, Raymond M Lebanon
DORSEY, MD, James T Lehigh
DORTCH, MD, Joseph Philadelphia
DORVILLE, MD, Fabio L Northampton
DORWART, MD, Bonnie B Philadelphia
DORWITT, MD, Deborah I Philadelphia
DOSHI, MD, Kirti K Philadelphia
DOSHI, MD, Nalini N Allegheny
DOSHI, MD, Narendra S Allegheny
DOSSETT, MD, John H Dauphin
DOSTAL, MD, Julie A Luzerne
DOTO JR, MD, Joseph B Northampton
DOTSEY, MD, Michael T Clearfield
DOTTERER, MD, Christine S Northumberland
DOTTERWAY, MD, Blanche E Westmoreland
DOTTOR, MD, Albinka J Lehigh
DOTTS EXEC, SEC, Carol Chester
DOUDS, MD, H Eugene Beaver
DOUDS, MD, Howard N Allegheny
DOUGHERTY, MD, Francis M Schuylkill
DOUGHERTY, MD, Joseph J Carbon
DOUGHERTY, MD, Malvin J Philadelphia
DOUGHERTY, MD, Michael J Delaware
DOUGHERTY, MD, Ralph N Allegheny
DOUGLAS, MD, Donald D Lycoming
DOUGLAS, MD, E Lorenzo Philadelphia
DOUGLAS, Leslie D Allegheny
DOUGLAS, MD, Pamela S Philadelphia
DOUGLASS, MD, Paul H York
DOUPE, MD, David W Erie
DOUWES, MD, Karel Philadelphia
DOVEY, MD, William C Franklin
DOVNARSKY, MD, James H Philadelphia
DOVYDAITIS, MD, Romas Lackawanna
DOWDELL, MD, Paul J Mercer
DOWLING, MD, John J Philadelphia
DOWLING, Richard J Students
DOWLUT, MD, Mohammad N Blair
DOWNES, MD, John J Philadelphia
DOWNEY, MD, Mark P Philadelphia
DOWNEY, MD, Thomas R Bradford
DOWNIE, MD, Robert W Montgomery
DOWNING, MD, Timothy M Crawford
DOWNS, DO, Carolyn R Bucks
DOYLE, MD, Albert F Cambria
DOYLE, MD, Alfred P Allegheny
DOYLE, MD, Faye R Chester
DOYLE, MD, John J Allegheny
DOYLE, MD, Russell G Chester
DRACOS, MD, Frank J Monroe
DRAGAN, MD, George A Allegheny
DRAGANN, DO, Raymond D Lancaster
DRAGANOSKY, MD, Eugene A Bucks
DRAGO, DO, John P Dauphin
DRAGO, MD, Joseph R Dauphin
DRAGOSLJVICH, MD, Mittie M Allegheny
DRAIN, MD, Randall T Philadelphia
DRANOV, MD, Jonathan Centre
DRAPER, MD, Nelle E Philadelphia
DRAPIEWSKI, MD, John F Luzerne
DRAPIEWSKI, MD, Vincent A Luzerne
DRASH, MD, Allan L Allegheny
DRATCH, MD, Michael B Philadelphia
DRATLER, MD, Marvin B Crawford
DRATMAN, MD, Mary B Philadelphia
DREAZEN, MD, Jonathan R Berks
DREER, MD, Aaron M Philadelphia
DREHER, MD, Robert H Northampton
DREIBELBIS, MD, William H Centre
DREIFUS, MD, Leonard S Philadelphia
DRENNEN JR, MD, James K Butler
DRESSEL JR, MD, Christopher J Lackawanna
DREW, MD, Frances L Allegheny
DREXLER, MD, Lawrence J Allegheny
DREZNER, MD, Malcolm E Bucks
DRINKER, MD, Henry M Philadelphia
DRISCOLL, MD, Deborah A Philadelphia
DRISCOLL, MD, Genevra Z Montgomery
DRISCOLL, MD, Richard H Carbon
DRISCOLL, MD, Robert A Crawford
DRISCOLL, DO, Robert W Montgomery
DRIZIN, MD, Gary S Montgomery
DROZDIAK, MD, Russell A Indiana
DRUBETSKIY, MD, Naum Philadelphia
DRUCKEMILLER, MD, William H Erie
DRUCKMAN, MD, Stephen M Lebanon
DRUFFNER, MD, Charles R Lackawanna
DRUFFNER JR, MD, Lewis C Lackawanna
DRUMHELLER, MD, John F Erie
DRY, MD, Frederick A Lehigh
DU PONT, DO, Daniel C Delaware
DUA, MD, Rup K Allegheny
DUANE, MD, Julia M Bucks
DUANE, MD, Thomas D Northampton
DUBB, MD, Jeffrey W Philadelphia
DUBBS, MD, Alfred W Lehigh
DUBEY, MD, Saroj K Erie
DUBLIN, MD, George J Philadelphia
DUBNANSKY, MD, John E Westmoreland

DUBOWITZ, MD, Leslie	Schuylkill
DUCA, MD, Peter R	Philadelphia
DUCHIN, MD, Harvey E	Philadelphia
DUCKETT JR, MD, John W	Philadelphia
DUDA, MD, Andrew M	Berks
DUDA, MD, John R	Philadelphia
DUDECK, MD, Carl R	Butler
DUDEK, MD, William C	Philadelphia
DUDENHOEFER, MD, Frederick J	Erie
DUDICH, MD, Michael S	Montgomery
DUERKSEN, MD, Roger L	Allegheny
DUFENDACH, MD, John H	Adams
DUFFY, MD, Clyde F	Allegheny
DUFFY, MD, Ruth E	Chester
DUFFY, MD, Scott S	Berks
DUGAN, Charles T	Students
DUGAN, MD, Thomas M	Erie
DUGAN JR, MD, Thomas M	Beaver
DUGGAN, MD, James H	Allegheny
DUGGAN JR, MD, Francis J	Dauphin
DUKE III, MD, Bruce E	Cambria
DUKER, MD, Daniel G	Allegheny
DULA, MD, David J	Montour
DULABON, MD, David A	Erie
DULABON, MD, George M	Allegheny
DULCEY JR, MD, John J	Bucks
DULL, MD, James A	Westmoreland
DUMARAN, MD, Delfa G	Montgomery
DUMAS, MD, Peter A	Philadelphia
DUMAS, MD, Peter R	Montgomery
DUNBAR, MD, John C	Allegheny
DUNCAN, MD, James R	Allegheny
DUNCAN, MD, Ralph E	York
DUNCAN, MD, Theodore G	Philadelphia
DUNDORE JR, MD, William C	Allegheny
DUNFORD, MD, Joseph L	Allegheny
DUNHAM, DO, Douglas A	Allegheny
DUNKLE, MD, Neil F	Lycoming
DUNMIRE, MD, Lester A	Allegheny
DUNMIRE, Susan M	Students
DUNN, MD, David D	Erie
DUNN, MD, David W	Crawford
DUNN, MD, Geoffrey P	Erie
DUNN, MD, James W	Delaware
DUNN, MD, Jeffrey M	Philadelphia
DUNN, MD, Jerome	Lehigh
DUNN, MD, Jonathan C	Allegheny
DUNN, MD, Joseph P	Venango
DUNN, MD, Lewis J	Philadelphia
DUNN, MD, Philip F	Huntingdon
DUNN, MD, William F	Venango
DUNNE, MD, Anne P	Montour
DUNNE, MD, Gay D	Centre
DUNNE, MD, James H	Centre
DUNNING, MD, E Ruth	Monroe
DUNSMORE, MD, Lillian D	Chester
DUNSMORE, MD, Richard A	Chester
DUNTON, MD, Charles J	Delaware
DUPLER, MD, Donald A	Philadelphia
DUPONT JR, MD, Philip J	Clearfield
DUPREY, MD, James G	Lancaster
DUPUIS JR, MD, Richard	Philadelphia
DURANT, MD, John R	Philadelphia
DURANTE, MD, Raphael H	Philadelphia
DURBECK, MD, Donald C	Dauphin
DURISEK, MD, George S	Dauphin
DURKAN, MD, Gerald	Allegheny
DURKIN, MD, Martin J	Montgomery
DURKIN, MD, Maureen L	Adams
DURNING, MD, Clifton M	Chester
DURNING, MD, Robert P	Allegheny
DUROCHER, MD, John R	Philadelphia
DURRWACHTER, MD, Robert J	Lycoming
DUSENBERRY, MD, Sarah J	Philadelphia
DUSINBERRE, MD, Robert Y	Tioga
DUTHINH, Vuong	Students
DUTLINGER, MD, Robert P	Dauphin
DUTTA, MD, Tarit K	Allegheny
DVORKIN, MD, Daniel	Chester
DY, MD, Belen O	Philadelphia
DY, MD, Victor C	Northampton
DYE, MD, Robert E	Dauphin
DYKYJ, MD, Roman	Philadelphia
DYKYJ JR, MD, Roman	Philadelphia
DYNAN, MD, James E	Montgomery
DYREYES, MD, Roberto R	Lebanon
DYSON, MD, William L	Philadelphia
DZIALOWSKI, MD, Kenneth J	Allegheny
DZIELAK, DO, Edward J	Lackawanna
DZUBOW, MD, Leonard M	Philadelphia
DZUREK, MD, William V	Schuylkill
DZWONCZYK JR, MD, John	Philadelphia

E

EAGEN, MD, Jeremiah W	Lackawanna
EAGER, MD, J Michael	Berks
EAGLE, MD, Perry A	York
EARICK, MD, Michael E	Erie
EARLE, MD, Martin F	Allegheny
EARLES, MD, Gordon H	Luzerne
EARLY, MD, Calvin B	Franklin
EARLY, MD, Robert F	Lebanon
EARNEST, MD, Tamar D	Lehigh
EASBY, MD, Mary H	Philadelphia
EASLER, MD, Richard E	Allegheny
EASTLAND, MD, Theodore W	Berks
EASTMAN III, MD, James T	Lancaster
EATER JR, MD, Charles L	Mifflin/Juniata
EATON, MD, Charlotta L	Allegheny
EATON, MD, David A	Northampton
EATON, MD, Edward H	Dauphin
EBERHART, MD, Joseph C	Bucks
EBERLEIN, MD, Walter R	Philadelphia
EBERLY, MD, David E	Delaware
EBERSOLE, MD, John H	Lancaster
EBERSOLE, MD, Thomas M	Berks
EBERTS, MD, Brian W	Allegheny
EBERZ, MD, Dennis A	Allegheny
ECHENBERG, MD, Robert J	Northampton
ECHIKSON, MD, Edward H	Montgomery
ECKBERG, MD, John J	Erie
ECKEL, MD, Timothy B	Columbia
ECKELS, DO, Dennis L	Cambria
ECKENRODE, MD, Joseph L	Lancaster
ECKER, MD, Malcolm L	Philadelphia
ECKER JR, MD, Herbert A	Lycoming
ECKER SR, MD, Herbert A	Lycoming
ECKERT, MD, Robert T	Butler
ECKROTH, MD, Richard N	Lebanon
EDBERG, MD, Sanford H	Allegheny
EDDINGER, MD, Leo C	Lehigh
EDDY, MD, Virginia A	Montour
EDEIKEN, MD, Jack	Philadelphia
EDELMAN, MD, Barry J	Dauphin
EDELSTEIN, MD, Abe J	Cambria
EDELSTEIN, MD, Joel K	Philadelphia
EDELSTEIN, MD, Norman L	Allegheny
EDER JR, MD, George E	York
EDGE, MD, Fred C	Fayette
EDINGTON, MD, John M	Philadelphia
EDMISTON, MD, Robert B	Dauphin
EDMONSTON, MD, George F	Armstrong
EDMUNDOWICZ, MD, Alphonse C	Dauphin
EDMUNDS, MD, Elizabeth H	Berks
EDMUNDS JR, MD, L Henry	Philadelphia
EDWARDS, MD, George E	Dauphin
EDWARDS, MD, Mary D	Allegheny
EDWARDS, MD, William M	Allegheny
EDWARDS, MD, William P	Venango
EGBERT, MD, E Wayne	Delaware
EGERMAN, MD, Leonard E	Allegheny
EGGLER, MD, Betsey A	Mifflin/Juniata
EGLESTON, MD, L Allan	Westmoreland
EGLICK, MD, Paul G	Philadelphia
EGOVILLE, MD, Charles R	Philadelphia
EHLER, MD, Joan G	Allegheny
EHLY, MD, George W	Cumberland
EHRHART, MD, Kenneth W	York
EHRLER, MD, August H	Erie
EHRLICH, MD, Dion R	Montgomery
EHRLICH, MD, Frank E	Cambria
EHRLICH, MD, George E	Philadelphia
EHRLICH, MD, Jeffrey N	Philadelphia
EHRLICH, MD, Leonard D	Montgomery
EICHENFIELD, MD, Lawrence F	Philadelphia
EICHER, MD, Wendell P	Bucks
EICHLER, MD, George R	Northampton
EICHLER, John A	Allegheny
EICHMILLER, MD, John P	Allegheny
EICHNER, MD, Lambert G	Delaware
EILER, MD, William A	Allegheny
EINHORN, MD, Jerzy	Allegheny
EISEMAN JR, MD, Paul C	Westmoreland
EISEN, MD, Carole L	Delaware
EISEN, MD, Howard B	Allegheny
EISENBEIS JR, MD, Carl H	Allegheny
EISENBERG, MD, Floyd P	Montgomery
EISENBERG, MD, H Grant	Berks
EISENBERG, MD, Richard B	Philadelphia
EISENHARDT, DO, Bruce T	Luzerne
EISENHOWER, MD, Charles E	York
EISENHOWER, MD, Edward A	Lancaster
EISLER, MD, Robert L	Butler
EISMAN, MD, Sylvan H	Philadelphia
EISNER, MD, Abraham G	Lackawanna
EISNER, MD, Clarence A	Allegheny
EISNER, MD, Henry	Philadelphia
EISNER, MD, Joel W	Chester
EISTER, MD, Ronald N	Lycoming
EKBERG, MD, Norman L	Montour
EKSTRAND, MD, John P	Allegheny
EL-ATTRACHE, MD, Mamdouh F	Westmoreland
ELANCHENNY, MD, Indranee	Chester
ELATTAR, MD, Anas A	Allegheny
ELATTRACHE, MD, Selim	Westmoreland
ELCOCK, MD, Claudius A	Philadelphia
ELDAIEF, MD, Samir F	Montgomery
ELDER, MD, E Glenn	Northampton
ELEFANT, MD, Howard L	Philadelphia
ELES, DO, Gustav R	Allegheny
ELFMAN, MD, Louis K	Philadelphia
ELFVIN, MD, Myra J	Philadelphia
ELHILLAL, MD, Mohammad F	Westmoreland
ELIADES, MD, William	Philadelphia
ELIAS, MD, Farid J	Westmoreland
ELIAS, MD, Stanton B	Allegheny
ELICKER, MD, John E	Delaware
ELIGATOR, MD, Julian	Allegheny
ELKOUSS, MD, Guillermo C	Philadelphia
ELKUS, MD, Robert M	Philadelphia
ELLEN, MD, Stephen J	Philadelphia
ELLENBERGER JR, MD, Thomas R	Cambria
ELLENZWEIG, MD, Morris S	Fayette
ELLIS, MD, Christina E	Delaware
ELLIS, MD, David M	Montgomery
ELLIS, MD, David W	Lebanon
ELLIS, MD, Edward S	Philadelphia
ELLIS, MD, George L	Allegheny
ELLIS, MD, Lawrence D	Allegheny
ELLIS, MD, Michael D	Montgomery
ELLIS, MD, Richard A	Philadelphia
ELLIS, MD, William	Philadelphia
ELLIS EDD EXEC, DIR, U Berkley	Montgomery
ELLIS JR, MD, Leander T	Philadelphia
ELLISON, MD, Ervin	Lancaster
ELLISON, MD, James H	York
ELLISON, MD, Julius	Philadelphia
ELLISON, MD, Neil M	Montour
ELLISON JR, MD, Richard T	Montgomery
ELMALEH, MD, Miriam K	Philadelphia
ELMER, MD, Edward M	Allegheny
ELOVIC, MD, Elie P	Philadelphia
ELSTNER, MD, Howard L	Allegheny
ELVIR, MD, Ramon	Warren
ELZENEINY, MD, Ismail H	Northampton
EMANUEL, MD, Abraham	Beaver
EMANUEL, MD, E Stephen	Delaware
EMERSON, MD, John A	Venango
EMERY, Brian E	Allegheny
EMERY, MD, Robert C	Northampton
EMES, MD, William R	Chester
EMKEY, MD, Kenneth D	Berks
EMKEY, MD, Ronald D	Berks
EMMERLING, MD, John F	Allegheny
EMMETT, MD, Gary A	Philadelphia
EMMOLO, MD, Alfonse A	Venango
ENANY, MD, Albert K	Fayette
ENCKE, MD, Ted K	Allegheny
ENDERS, MD, John G	Franklin
ENDRES, MD, Warren H	Lehigh
ENERSON, MD, Daniel M	Allegheny
ENGEL, MD, Gilson C	Philadelphia
ENGEL, MD, Milton I	Erie
ENGELHARDT, MD, David S	Bradford
ENGINEER, MD, Erach H	Philadelphia
ENGLAND, MD, Kenneth B	Blair
ENGLE, MD, Eugene K	Lancaster
ENGLE, MD, Harold H	Lebanon
ENGLE, MD, Joseph H	Franklin
ENGLISH, MD, Carroll A	Montgomery
ENGLISH, MD, Dennis H	Allegheny
ENGLISH, MD, James B	Blair
ENGLISH, MD, Joseph G	Lycoming
ENGLISH, MD, O Spurgeon	Philadelphia
ENGLISH, MD, Richard B	Luzerne
ENGLISH, MD, Robert S	Fayette
ENGLISH JR, MD, Walter E	Clinton
ENGSTROM, MD, Paul F	Philadelphia
ENNIS, MD, Michael F	Allegheny
ENRIQUEZ, MD, Teresita E	Allegheny
ENSMINGER, MD, Chalmers D	York
ENTERLINE, MD, Horatio T	Philadelphia
ENTINE, MD, Joseph H	Philadelphia
ENTMACHER, MD, Susan D	Montgomery
ENTWISTLE, MD, Nelson L	Dauphin
ENYEART, MD, Harvey F	Westmoreland
EPERJESSY, MD, Ernest Z	Cambria
EPISCOPIO, MD, Joseph V	Northampton
EPPINGER, MD, Mary A	Allegheny
EPSTEIN, MD, Herman	Philadelphia
EPSTEIN, MD, Isadore S	Philadelphia
EPSTEIN, MD, J David	Philadelphia
ERB, MD, Kathleen M	Erie
ERB, MD, William H	Delaware
ERB JR, MD, William H	Delaware
ERDMAN, MD, Robert M	Schuylkill
ERDMAN II, MD, William J	Philadelphia
EREMUS, MD, Joseph L	Philadelphia
ERHART, John F	Students
ERICKSEN, MD, Arthur N	Berks
ERICKSON, MD, Elmer W	Allegheny
ERICKSON, MD, Eric R	Allegheny
ERICKSON, MD, Ray B	Clarion
ERICSSON, MD, Francis S	Warren
ERMOLD, MD, Donald R	Berks
ERSLEV, MD, Allan J	Philadelphia
ERSNER, MD, Arthur R	Montgomery
ERSNER, MD, Jack S	Philadelphia
ERSOZ, MD, Clara J	Allegheny
ERVIN, MD, Carl E	Dauphin
ERVIN, MD, Lawrence M	Blair
ERWAY, MD, Preston M	Tioga
ERWIN, MD, Henry K	Northampton
ESBENSHADE II, MD, John H	Lancaster
ESCARO, MD, Danilo U	York
ESCARTE, MD, Deogracias E	Philadelphia
ESCOLL, MD, Philip J	Philadelphia
ESGUERRA JR, MD, Pablo R	Fayette
ESHBACH, MD, Ted B	Dauphin
ESHELMAN, MD, Joseph C	Fayette
ESHLEMAN, MD, D Rohrer	Lancaster
ESHLEMAN, MD, John D	Lancaster
ESHLEMAN, MD, S Kendrick	Lancaster
ESKENAZI, MD, Marko M	Philadelphia
ESKENDRI, MD, Nasser	Beaver
ESKIN, MD, Bernard A	Philadelphia
ESKIN, MD, David J	Montgomery
ESKRIDGE, MD, Timothy H	York
ESLER JR, MD, James W	Lehigh
ESPARRAGUERA, MD, Francisco	Venango
ESPINOSA, MD, Manuel H	Northampton
ESPOSITO, MD, Frances S	Philadelphia
ESPOSITO, MD, Francis A	Allegheny
ESPOSITO, MD, John C	Delaware
ESPOSITO, MD, Joseph P	Dauphin
ESTLUND, MD, Gregory J	Philadelphia
ESTNER, MD, Michael J	Allegheny
ETNOYER, MD, John J	Lancaster
ETTENGER, MD, Morris S	Philadelphia
ETTER, MD, Russel H	York
ETTINGER, MD, Jeffrey B	Philadelphia
ETTLINGER, MD, Robert A	Dauphin
ETZI, Susan	Students
ETZL, MD, Michael M	Philadelphia
EULIANO JR, MD, John J	Erie
EULIANO SR, MD, John J	Erie
EVANGELISTA, MD, Evaristo U	Philadelphia
EVANGELISTA, MD, Jesus S	Washington
EVANGELISTA, MD, Simplicio E	Montgomery
EVANKO, MD, David A	Butler
EVANS, MD, Charles M	Lancaster
EVANS, MD, David B	Cumberland
EVANS, MD, Donald E	Allegheny
EVANS, MD, Harold H	Union
EVANS, MD, Hayden O	Montgomery
EVANS, MD, Hilary	Cambria
EVANS, MD, James F	Montour
EVANS, DO, John C	Centre
EVANS, MD, John J	Carbon
EVANS, MD, Joseph B	Philadelphia
EVANS, MD, Leonard E	Allegheny
EVANS, MD, Richard S	Allegheny
EVANS, MD, Robert J	Bucks
EVANS, MD, Robert L	York
EVANS, MD, Thomas M	Allegheny
EVANS, MD, Timothy C	Allegheny
EVANS, MD, William G	Indiana
EVANS EXEC, SEC, Robert W	Dauphin
EVANS II, MD, Lewis C	Bradford
EVERETT, MD, Harold E	Lehigh
EVERETT, MD, William G	Allegheny
EVERHART, MD, Charles W	Mifflin/Juniata
EVERHART, MD, Wilson C	Dauphin
EVERLOF, MD, Sherman W	Delaware
EVERTS, MD, Glenn S	Philadelphia
EVES, MD, John H	Bucks
EVRON, MD, Wayne A	Allegheny
EWALD, MD, John L	Allegheny
EWING, MD, Agnew R	Chester
EWING, MD, Charles H	Montgomery
EWING, MD, Fred L	Crawford
EWING, MD, James H	Philadelphia
EWING, MD, Madeleine Q	Philadelphia
EYERLY, MD, Robert C	Montour
EYLER, MD, J Albert	Bedford
EYLER, MD, Paul W	Lancaster
EYMONTT, MD, Michael J	Philadelphia
EYSTER, MD, M Elaine	Dauphin
EYVAZZADEH, MD, Camille	Northampton

F

FABER, MD, Frederick S	Dauphin
FABER, MD, Kalman	Philadelphia
FABER, Scott H	Allegheny
FABI, MD, Mario N	Lackawanna
FABINYI, MD, Geza T	Blair
FABIUS, MD, Raymond J	Delaware
FABRY, MD, Edward I	Allegheny
FACKLER, MD, Emerson F	Dauphin
FAGELMAN, MD, Kerry M	Dauphin
FAGER, MD, Charles B	Dauphin
FAGER, MD, Joseph S	Dauphin
FAGERBURG, MD, Rodger E	Lackawanna
FAGIOLETTI, MD, Robert J	Washington
FAHL, MD, James C	Monroe
FAHMY, MD, Wasfy F	Chester
FAILLA, MD, Jack P	Allegheny
FAIRBROTHER, MD, Paul F	Dauphin
FAIRES, MD, James S	Delaware
FAIRFIELD, MD, James C	Montgomery
FAIRMAN, MD, Ronald M	Philadelphia
FAIRWEATHER, MD, Jack L	Union
FAJARDO, MD, Arturo A	Lycoming
FAKHRAEE, MD, Sayyed M	Philadelphia
FALBO, MD, Santo J	Lackawanna
FALCHEK, MD, Joseph B	Mifflin/Juniata
FALCO, MD, Frank G	Bucks
FALCO, Frank J E	Students
FALCON JR, MD, Joseph R	Allegheny
FALCONE, MD, Domenico	Lehigh
FALGUERA, MD, Dominador Q	Delaware
FALK, MD, Arthur E	Montgomery
FALK, MD, Edward C	Mercer
FALK JR, MD, Robert B	Lancaster
FALKENBERG, MD, Gisela H G	Bradford
FALKENBERG, MD, K Jorg	Bradford
FALKER, MD, John M	Montgomery
FALL, MD, Michael H	Blair
FALLAHNEJAD, MD, Manoucher	Philadelphia
FALLON III, MD, Edward C	Berks
FALOR, MD, Stanley E L	Greene
FALUDI, MD, Georgina	Philadelphia
FALVO, MD, Ernest A	Allegheny
FAMORCA, MD, Florentino P	Lycoming
FAN, MD, Young C	Venango
FANFERA, MD, Francis J	Chester
FANNIN, MD, Thomas S	Bucks
FANNING, DO, John M	Delaware
FARACE, MD, Joseph L	Northampton
FARAGALLA, MD, Ramses I	Franklin
FARB, MD, Stanley N	Montgomery

FARBER, MD, Barry M	Philadelphia
FARBER, MD, Bruce F	Allegheny
FARBER, MD, David N	Berks
FARBER, MD, Eric B	Berks
FARBER, MD, Harold I	Berks
FARBER, MD, John L	Philadelphia
FARBER, MD, Martin	Philadelphia
FARIES JR, MD, George B	Dauphin
FARKAS, MD, Andrew A	Jefferson
FARKAS, MD, Barry L	Allegheny
FARKAS, MD, Robert W	York
FARLEY, MD, James C	Lackawanna
FARMATI, MD, Oscar	Crawford
FARMER, MD, Harold E	Montgomery
FARMER, MD, John L	Lancaster
FARMER, MD, Lenore	Allegheny
FARMER, MD, Rodney A	Montgomery
FARNEY, MD, Esther S	Allegheny
FARNON, MD, Ulrike L	Philadelphia
FARO, Albert	Allegheny
FARQUHAR, MD, John D	Philadelphia
FARR, MD, James	Carbon
FARR, MD, Russell M	Allegheny
FARRAR JR, MD, George E	Philadelphia
FARRELL, MD, Dorothy A	Luzerne
FARRELL, MD, Edward L	Allegheny
FARRELL, Melanie A	Students
FARRELL, MD, Peter E	Lehigh
FARRELL, MD, Robert E	Lackawanna
FARRELL, MD, Thomas A	Philadelphia
FARRELL, MD, William J	Erie
FARRELL, MD, William J	Lackawanna
FASCIANA, MD, Guy M	Luzerne
FAST, MD, Willis B	Bucks
FATEMI, MD, Jalal B	Luzerne
FATO, Michelina	Allegheny
FATULA, MD, George M	Jefferson
FATUR, MD, Leo M	Allegheny
FAUNCE III, MD, James G	Bucks
FAUST, MD, Donald S	Berks
FAUST, MD, Elizabeth B	Delaware
FAUST, MD, Herbert A	Chester
FAUST, MD, Michael G	Philadelphia
FAVA, MD, George E	Lebanon
FAVAZZA, MD, Frank W	Northampton
FAVINI, MD, Josephine L	Lackawanna
FAVINI, MD, M Peter	Lackawanna
FAVINI, MD, Peter J	Philadelphia
FAVINO, MD, C James	Montour
FAWCETT, MD, James L	Allegheny
FAYE, MD, Robyn B	Philadelphia
FAZIO, MD, Anthony N	Lackawanna
FEAR, MD, Jesse G	Columbia
FEASTER, MD, Marshall M	Berks
FEBBRARO, MD, Anthony A	Montgomery
FECZKO, MD, William A	Allegheny
FEDDIS, MD, Grania	Allegheny
FEDELE, MD, Charles R	Bradford
FEDERICI, MD, Valerio J	Philadelphia
FEDERMAN, MD, Jay L	Delaware
FEE JR, MD, William H	Venango
FEEHAN, MD, Patrick R	Lancaster
FEEMAN, MD, Theresa J	Erie
FEENEY, MD, Robert A	Lehigh
FEERICK, MD, John P	Luzerne
FEES JR, MD, Arch W	Blair
FEHNEL, MD, Stephen H	Berks
FEICHT, DO, Charles M	Beaver
FEICK, MD, Ralph H	Berks
FEIG, MD, Stephen A	Philadelphia
FEIGLEY, MD, Donald M	Bucks
FEIN, DO, Howard K	Montgomery
FEINBERG, MD, David H	Northampton
FEINBERG, MD, Michael J	Philadelphia
FEINER, MD, Larry A	Chester
FEINGOLD, MD, Joseph L	Delaware
FEINSTEIN, MD, Michael A	Montgomery
FEINSTEIN, MD, Peter A	Luzerne
FEINSTEIN, MD, Steven A	Philadelphia
FEINSTEIN, MD, Theodore A	Philadelphia
FEIST, MD, John H	Allegheny
FELDER, MD, Herman	Allegheny
FELDMAN, MD, Arthur M	Philadelphia
FELDMAN, MD, Ella S	Philadelphia
FELDMAN, MD, Julian D	Philadelphia
FELDMAN, MD, Larry B	Lehigh
FELDMAN, MD, Stewart L	Allegheny
FELDMEIER, MD, Curtis J	Beaver
FELICE, MD, Civie D	Allegheny
FELIX, MD, Dionisio	Philadelphia
FELLERMAN, MD, Herbert	Luzerne
FELTWELL JR, MD, Peter M	Allegheny
FENCEL, MD, Richard M	Dauphin
FENLIN JR, MD, John M	Philadelphia
FENN, MD, Patricia A	Montgomery
FENNER, MD, Henry E	Lycoming
FENSTER, MD, Martin M	Philadelphia
FENTON, MD, Ivor	Schuylkill
FEO, MD, Louis G	Philadelphia
FERENCI, MD, David A	Philadelphia
FERENZI, MD, James C	Bradford
FERER, MD, Walter C	Crawford
FERGUSON, MD, Donald G	Allegheny
FERGUSON, MD, Emanuel R	Philadelphia
FERGUSON, MD, Robert H	Lancaster
FERGUSON, MD, Roger J	Allegheny
FERGUSON, MD, Thomas G	Allegheny
FERGUSON JR, MD, Albert B	Allegheny
FERGUSON JR, MD, Guerrant H	Philadelphia
FERGUSON JR, MD, Theodore J	Allegheny
FERLAN, MD, Lawrence	Allegheny
FERNANDEZ, MD, Eduardo I	Lycoming
FERNANDEZ, MD, Maureen E	Philadelphia
FERNANDEZ, MD, Oscar V	Erie
FERNANDO, MD, Michael F	Blair
FERNANDO, MD, Neville A	Erie
FERRARA, MD, Frank M	Lehigh
FERRARA, MD, Vincent L	Philadelphia
FERRARO, MD, Michael M	Luzerne
FERRARO, MD, Patrick J	Lackawanna
FERRARO, MD, Robert J	Erie
FERREIRA, MD, Arturo J	Philadelphia
FERRI, MD, Henry G	Allegheny
FERRIER, MD, Melvin C	Centre
FERRIGNO JR, MD, Carmen J	Columbia
FERRONI, MD, Joseph S	Delaware
FERRUCCI JR, MD, William S	Jefferson
FERRY, MD, Gerald W	Berks
FERRY, MD, Nicholas J	Bucks
FERSON, MD, Peter F	Allegheny
FESCINA, MD, Joseph V	Luzerne
FESNIAK, MD, Henry F	Montour
FETCHKO, MD, Alexander M	Allegheny
FETTER, MD, Ferdinand	Philadelphia
FETTERHOFF, MD, Kenneth I	Allegheny
FETTERMAN, MD, George H	Allegheny
FETTERMAN, MD, Henry H	Lehigh
FETTEROLF, MD, Donald E	Allegheny
FETTEROLF, MD, Michael L	Venango
FETZER, MD, Arthur E	Lehigh
FEUDALE, MD, Richard F	Schuylkill
FEUSSNER, MD, James W	Philadelphia
FICKE, MD, J Ronald	Philadelphia
FIDELER, MD, Richard	Dauphin
FIDEN JR, MD, William J	Beaver
FIEDLER, MD, Howard T	Lehigh
FIEDLER, MD, James J	Philadelphia
FIEDLER, MD, Roy W	Allegheny
FIEHLER, MD, Paul C	Allegheny
FIELD, MD, Howard L	Philadelphia
FIELD, MD, John M	Dauphin
FIELD-MUNVES, MD, Ellen M	Lehigh
FIELDING, Julia R	Allegheny
FIELDS, MD, Harry	Philadelphia
FIERER, MD, Robert R	Dauphin
FIGLIN, DO, Joshua M	Centre
FIGUEROA, MD, Peter R	Philadelphia
FIGUEROA, MD, William G	Philadelphia
FIGURA, MD, Judith H	Allegheny
FIKRI, MD, Erden	Cambria
FILE, MD, James C	Mercer
FILIP, MD, John R	Montgomery
FILIPEK, MD, Steele W	Allegheny
FILIPEK, MD, Walter J	Northampton
FILIPPONE, MD, Edward J	Philadelphia
FILLMAN, MD, John B	Huntingdon
FILMYER JR, MD, Edward A	Philadelphia
FILOSA, MD, Robert J	Montgomery
FINCH, MD, Alberta M	Monroe
FINCH, MD, Frank G	Lehigh
FINDER, MD, Marc J	Cambria
FINE, MD, Alan	Allegheny
FINE, Caryn	Allegheny
FINE, MD, Daniel	Allegheny
FINE, MD, Edward M	Crawford
FINE, MD, Eric W	Philadelphia
FINE, MD, Robert	Montgomery
FINEBERG, MD, Charles	Philadelphia
FINEGOLD, MD, Aaron N	Allegheny
FINEGOLD, MD, Joseph	Allegheny
FINEGOLD, MD, Richard A	Allegheny
FINEGOLD, MD, Wilfred J	Allegheny
FINEMAN, MD, William	Philadelphia
FINESTONE, MD, Albert J	Philadelphia
FINESTONE, MD, Israel	Philadelphia
FINESTONE, MD, Stephen C	Allegheny
FINGERET, MD, Arnold E	Allegheny
FINGERUT, MD, Jerald C	Montgomery
FINGO, MD, Albert J	Montgomery
FINK, MD, Jack W	Montgomery
FINK, MD, Paul J	Philadelphia
FINK, MD, William L	Beaver
FINK JR, MD, Albert H	Delaware
FINK JR, MD, Howard E	Dauphin
FINKELHOR, MD, Howard B	Allegheny
FINKELSTEIN, MD, Amy H	Philadelphia
FINKELSTEIN, MD, David	Philadelphia
FINKELSTEIN, MD, Gary S	Bucks
FINKELSTEIN, MD, Herman	Lycoming
FINKELSTEIN, MD, Sydney D	Philadelphia
FINLAY, MD, James W	Allegheny
FINLEY, MD, John G	Bucks
FINN, MD, David R	Lycoming
FINN, MD, Joanne	Erie
FINN, MD, Joseph L	Philadelphia
FINN, MD, Martha J B	Lycoming
FINNEGAN, MD, James O	Philadelphia
FINNEGAN, Matthew J	Students
FINNESON, MD, Bernard E	Philadelphia
FINO, MD, Julius A	Warren
FIOL-SILVA, MD, Zoraida M	Philadelphia
FIRPO JR, MD, John J	Delaware
FIRST, MD, Arthur	Philadelphia
FIRST, MD, Howard E	Philadelphia
FIRST, MD, Stewart E	Philadelphia
FIRTH, MD, George E	Philadelphia
FISCHBACH, MD, Max W	Philadelphia
FISCHER, MD, Carl C	Philadelphia
FISCHER, MD, David H	Philadelphia
FISCHER, MD, Edward C	Berks
FISCHER, MD, H Keith	Philadelphia
FISCHER, MD, Richard L	Philadelphia
FISCHER, MD, Rolf H	Schuylkill
FISCHER, MD, Sandra L	Philadelphia
FISCHER, MD, Sharon P	Philadelphia
FISCHER JR, MD, Carl R	Philadelphia
FISCHETTI, MD, John L	Chester
FISCHL, MD, Edwin C	Allegheny
FISHBEIN, Debbie E	Students
FISHER, MD, Alvin H	Montgomery
FISHER, MD, Bernard	Allegheny
FISHER, MD, Curtis K	Allegheny
FISHER, MD, Don L	Allegheny
FISHER, MD, Gail	Allegheny
FISHER, DO, Gary A	Philadelphia
FISHER, MD, Harold	York
FISHER, MD, John T	Centre
FISHER, MD, Joseph S	Philadelphia
FISHER, MD, Lawrence C	York
FISHER, MD, Luther I	Northampton
FISHER, Mark A	Students
FISHER, MD, Mary S	Philadelphia
FISHER, MD, Norman J	Montgomery
FISHER, MD, Philip C	Bradford
FISHER, MD, Robert A	Dauphin
FISHER, MD, Robert M	Montgomery
FISHER, MD, Robert S	Philadelphia
FISHER, MD, Roscoe L	York
FISHER, MD, Seth M	Philadelphia
FISHER, MD, Seth W	Bradford
FISHER, MD, Stephen N	Allegheny
FISHER, MD, T Forrest	Allegheny
FISHER III, MD, George R	Philadelphia
FISHER JR, MD, Joseph W	Northampton
FISHKIN, MD, Hymel	Allegheny
FISHMAN, MD, Aaron E	Philadelphia
FISHMAN, Alan	Students
FISHMAN, Craig L	Allegheny
FISK, MD, David E	Montour
FISSEL, MD, George E	Lycoming
FISTER, MD, Frederick D	Lehigh
FITTING JR, MD, George M	Allegheny
FITZGERALD, MD, James L	Lehigh
FITZGERALD, MD, Richard P	Dauphin
FITZMAURICE, MD, John W	Delaware
FITZPATRICK, DO, James W	Schuylkill
FITZPATRICK, MD, Marcia A	Delaware
FITZPATRICK, MD, Ruthann P	Delaware
FITZSIMMONS, MD, William R	Butler
FITZSIMONS, MD, Thomas R	Lehigh
FLACCO, MD, Albert J	Bucks
FLAMBERG, MD, Ira W	Mercer
FLAMINI, MD, John A	Erie
FLANAGAN, MD, H Franklin	Philadelphia
FLANAGAN, MD, John V	Northumberland
FLANAGAN, MD, Joseph C	Delaware
FLANAGAN, MD, Margaret M	Franklin
FLANAGAN, MD, Michael D	Philadelphia
FLANDERS, MD, Elwood P	York
FLANIGAN JR, MD, John L	Schuylkill
FLANNAGAN, MD, Samuel W	Westmoreland
FLANNERY, MD, Wilbur E	Lawrence
FLEAGLE, MD, Genevra S	Centre
FLEAGLE, MD, Samuel B	Centre
FLEEGLER, MD, Francene M	Philadelphia
FLEEGLER, MD, Saul M	Westmoreland
FLEISCHER, MD, Alan N	Berks
FLEISCHER, MD, Leslie R	Lancaster
FLEISCHER, MD, Scott A	Philadelphia
FLEISHER, DO, Richard D	Philadelphia
FLEISHMAN, MD, Martin J	Mifflin/Juniata
FLEMING, MD, Arthur W	Allegheny
FLEMING, MD, Burton A	Philadelphia
FLEMING, MD, George E	Blair
FLEMING, MD, Kenneth D	Philadelphia
FLEMING, MD, Kevin M	Lawrence
FLEMING, MD, Richard M	Allegheny
FLETCHER, MD, Louis	Philadelphia
FLETCHER, MD, Ronald M	Dauphin
FLETCHER, MD, Thomas F	Dauphin
FLICKINGER, MD, Frederick W	York
FLINKMAN, MD, Leonard	Philadelphia
FLINN, Scott D	Allegheny
FLIT, MD, Frank J	Allegheny
FLOM, MD, David M	Allegheny
FLOOD, MD, James M	Bradford
FLOOD, MD, Jill T	York
FLORA, MD, William K	Cambria
FLOREK, MD, Florian F	Erie
FLORENTIN, MD, Heriberto M	Westmoreland
FLORES, MD, Alberto C	Lancaster
FLORES, MD, Carlos I	Lawrence
FLORES, MD, Evelyn R	Berks
FLORES, MD, Maria L	Delaware
FLORES, MD, May R	Beaver
FLORES, MD, Susan G	Venango
FLORES, MD, Toribio C	Venango
FLORES JR, MD, Emilio G	Elk/Cameron
FLORES JR, James H	Students
FLORO, MD, Claro N	Philadelphia
FLOWERS, MD, Peter B	Lebanon
FLOYD, MD, Susan L	Allegheny
FLURKEY, MD, Emerson C	Dauphin
FLYNN, MD, Richard J	Bradford
FOCHLER, MD, Francis J	Blair
FODERARO, MD, John C	Philadelphia
FOGEL, MD, Sari N	Philadelphia
FOGEL, MD, Stewart R	Allegheny
FOGLEY, MD, Anees R	Lackawanna
FOKSTUEN, MD, Terje S	Mckean
FOLDES, MD, Julius	Luzerne
FOLDES, MD, Steven I	Montour
FOLDES, MD, Veronika M	Montour
FOLDES-ROTH, MD, Elisabeth	Berks
FOLEY JR, MD, Edward L	Washington
FOLLMER, MD, Don C	Northampton
FOLTZ EXEC, SEC, Ms Susan	Lebanon
FONG, MD, Jake	Westmoreland
FONOROFF, MD, David L	Allegheny
FONTANA, MD, Armand L	Allegheny
FONTANA, MD, Frank L	Allegheny
FONTANETTA, MD, John A	Philadelphia
FONTANILLA, MD, Rodolfo C	Philadelphia
FONTE, MD, Richard J	Dauphin
FOOSKAS, MD, Stephen P	Lehigh
FOOTE, MD, Jenelle E	Philadelphia
FOOTE, Joseph W	Students
FOOTERMAN, MD, Harold	Allegheny
FORBES, MD, Thomas W	Allegheny
FORCE, MD, Thomas B	Philadelphia
FORCEY, MD, Clarke M	Centre
FORCEY, MD, Lloyd R	Lycoming
FORD, MD, Francis W	Bucks
FORD, MD, Robert W	Allegheny
FORD, MD, William B	Allegheny
FORD, MD, William T	Lycoming
FOREMAN, MD, Joseph	Philadelphia
FOREST, MD, Jean L	Philadelphia
FOREST, MD, Pamela J	York
FORKER, MD, Thomas	Lebanon
FORKER, MD, Thomas S	Lycoming
FORMAN, MD, Harvey R	Philadelphia
FORMAN, Howard I	Students
FORMAN, MD, Irwin H	Lancaster
FORMAN, Jeffrey D	Students
FORMAN, MD, Joseph E	Philadelphia
FORMAN, MD, Kenneth J	Philadelphia
FORMAN, MD, Samuel	Philadelphia
FORMAN, MD, Simon B	Philadelphia
FORNASIER, MD, Louis S	Delaware
FORNWALT, MD, George R	Delaware
FORNWALT, MD, Helen L	Philadelphia
FORREY EXEC SEC, Candy	Monroe
FORSE JR, MD, David P	Blair
FORSTATE, MD, William J	Allegheny
FORSTATER, MD, Alan T	Philadelphia
FORSTER, DO, Carl J	Schuylkill
FORSTER, MD, Robert S	Allegheny
FORSYTHE, MD, Patrick D	Dauphin
FORTI, MD, William P	Dauphin
FORTNUM, MD, Walter G	Bucks
FORTUNATO, MD, James J	Allegheny
FOSS, MD, David E	Allegheny
FOSTER, MD, Frederick G	Butler
FOSTER, MD, Howard K	Allegheny
FOSTER, MD, Ian S	Montour
FOSTER, MD, John S	Chester
FOSTER, MD, Mark R	Crawford
FOSTER, MD, Sylvia L	Montgomery
FOSTER, MD, Walter D	Westmoreland
FOSTER, MD, Walter R	Allegheny
FOSTER, Wayne P	Students
FOSTER JR, MD, John V	Dauphin
FOULK JR, MD, Morris	Delaware
FOULSHAM II, MD, Charles K	Clinton
FOURHMAN-OLEWILER EX, SEC, Mrs Kath	York
FOURNIER, MD, Raymond	Luzerne
FOUST, MD, Tilman H	Dauphin
FOUST, MD, Wilson A	Lancaster
FOW, Fred A	Students
FOX, MD, Charles F	Armstrong
FOX, MD, Craig D	Washington
FOX, MD, Donald	Philadelphia
FOX, MD, Donald C	Butler
FOX, MD, Michael L	Delaware
FOX, MD, Robert D	Philadelphia
FOX, MD, Roger E	Delaware
FOX, MD, Stephen C	Chester
FOX, MD, Stewart	Lehigh
FOX, MD, William F	Lehigh
FOX IV, MD, James W	Philadelphia
FOXX, MD, William F	Chester
FRABLE, MD, Dean G	Schuylkill
FRAILEY JR, MD, William W	Lehigh
FRAKES, MD, Shirley I	Philadelphia
FRALEY, MD, Henry W	Armstrong
FRALICK, MD, Jerry L	Allegheny
FRAME, MD, David C	Washington
FRANCE, MD, Laurence W	Lancaster
FRANCIS, MD, George J	Allegheny
FRANCIS, MD, Leon R	Luzerne
FRANCO, MD, Alexander	Centre
FRANCOIS, MD, Max B	Berks
FRANGIPANE, MD, Leo G	Berks
FRANGOS, MD, James N	Lackawanna
FRANK, MD, Barbara B	Delaware
FRANK, MD, Herbert L	Dauphin
FRANK, MD, Jeffrey B	Berks
FRANK, MD, Leonard A	Montgomery
FRANK, MD, Martin N	Montgomery
FRANK, MD, Patrick J	Lebanon
FRANK, MD, Paul E	Montgomery
FRANK, MD, Reuben	Montgomery
FRANK, MD, Robert L	Montgomery
FRANKE, MD, Frederick R	Allegheny
FRANKEL, MD, Arthur M	Montgomery
FRANKEL, MD, Gerald J	Lycoming

FRANKEL, MD, Harry A	Philadelphia
FRANKEL, MD, Leon A	Philadelphia
FRANKEL, MD, Leslie B	Montgomery
FRANKEL, MD, Matthew C	Philadelphia
FRANKEL, MD, Sharon R	Philadelphia
FRANKENFIELD, MD, Bruce A	Lehigh
FRANKENSTEIN, MD, Herbert	Allegheny
FRANKL, MD, William S	Philadelphia
FRANKLIN, MD, Donald S	Fayette
FRANKLIN, MD, Irvin D	Bucks
FRANKLIN, MD, John W B	Allegheny
FRANKOVITCH, MD, Karl F	Erie
FRANKWICK, MD, Dawn M	Philadelphia
FRANTZ, MD, Alfred S	Franklin
FRANTZ, MD, Robert C	Berks
FRANTZ, MD, Robert R	Carbon
FRANZ, MD, John P	Allegheny
FRASER, Douglas H	Students
FRATTALI, MD, August	Lackawanna
FRAUENHOFFER, MD, Christopher M	Montgomery
FRAUENHOFFER, MD, Elizabeth E	Dauphin
FRAUNFELDER, MD, John A	Northampton
FRAYER, MD, William C	Philadelphia
FRAZIER, MD, Thomas G	Montgomery
FRAZIER II, MD, John E	Allegheny
FREAS, MD, David G	York
FREDA, MD, Richard N	Indiana
FREDERIC, MD, Myron W	Philadelphia
FREDERICK, MD, David W	Lancaster
FREDERICK, MD, Paul L	Armstrong
FREDERICKS, MD, Lillian E	Philadelphia
FREDERICKSON, MD, Howard N	York
FREDRICKSON, MD, Victor J	Bucks
FREED, MD, Clarence L	Bucks
FREEDBERG, MD, Lawrence E	Westmoreland
FREEDMAN, MD, Abraham G	Philadelphia
FREEDMAN, MD, Alan R	Philadelphia
FREEDMAN, MD, Allan P	Philadelphia
FREEDMAN, MD, Donald B	Dauphin
FREEDMAN, MD, E Fannie	Philadelphia
FREEDMAN, MD, Jacob J	Philadelphia
FREEDMAN, MD, Lawrence T	Montgomery
FREEDMAN, MD, Louis J	Luzerne
FREEHAFER, MD, John F	Chester
FREELAND, MD, George R	Delaware
FREEMAN, MD, Albert W	Franklin
FREEMAN, MD, Ian L	Allegheny
FREEMAN, MD, Joseph T	Philadelphia
FREEMAN, MD, Leo C	Chester
FREEMAN, MD, Margaret L	Philadelphia
FREEMAN, MD, William A	Franklin
FREENOCK JR, MD, Thomas F	Delaware
FREIFELD, MD, Martin L	Luzerne
FREILICH, MD, Howard S	Philadelphia
FREIMANIS, MD, Maija G	Allegheny
FREIMUTH, MD, Erich J	Montgomery
FREIWALD, MD, Milton J	Philadelphia
FREMD, MD, Mark S	Allegheny
FREMER, MD, Abraham	Philadelphia
FRENCH, MD, Elizabeth G	Chester
FRENCH, MD, Gordon N	Chester
FRENCH, MD, Travis A	Lawrence
FRESHMAN, MD, John R	Dauphin
FREY, MD, Jeffrey A	York
FREYMAN, MD, Leon	Montgomery
FREYNIK, MD, Joseph G	Lycoming
FRICCHIONE, MD, Patrick J	Philadelphia
FRIDAY, MD, Daniel M	Blair
FRIDAY, MD, Gilbert A	Allegheny
FRIDAY, MD, John R	Allegheny
FRIDAY, MD, Rupert H	Allegheny
FRIED, MD, Jeffrey A	Indiana
FRIED, MD, Martin B	Luzerne
FRIEDBERG, MD, Jay G	Bucks
FRIEDBERG, MD, Milton J	Lehigh
FRIEDENBERG, MD, Steven S	Northampton
FRIEDENBERG, MD, Zachary B	Philadelphia
FRIEDLAND, MD, Richard J	Philadelphia
FRIEDLANDER, MD, Milton A	Dauphin
FRIEDLANDER, MD, Myron	Allegheny
FRIEDMAN, MD, Abraham W	Allegheny
FRIEDMAN, MD, Adele K	Philadelphia
FRIEDMAN, MD, Bart J	Westmoreland
FRIEDMAN, MD, Donald	Delaware
FRIEDMAN, MD, Edward S	Allegheny
FRIEDMAN, MD, Ellis F	Berks
FRIEDMAN, MD, Gerald M	Columbia
FRIEDMAN, MD, Henry B	Luzerne
FRIEDMAN, MD, Irwin	Bucks
FRIEDMAN, MD, Jeffrey	Philadelphia
FRIEDMAN, MD, Jerald N	Northampton
FRIEDMAN, MD, Jon R	Montgomery
FRIEDMAN, MD, Louis L	Allegheny
FRIEDMAN, MD, Mark C	Dauphin
FRIEDMAN, DO, Martin L	Philadelphia
FRIEDMAN, MD, Milton L	Philadelphia
FRIEDMAN, MD, Monte R	Philadelphia
FRIEDMAN, MD, Paul S	Philadelphia
FRIEDMAN, MD, Phillip	Bucks
FRIEDMAN, MD, Richard A	Philadelphia
FRIEDMAN, MD, Robert B	Allegheny
FRIEDMAN, Robert J	Allegheny
FRIEDMAN, MD, Ronald H	Philadelphia
FRIEDMAN, MD, Sidney	Philadelphia
FRIEDMAN, MD, Sumner H	Dauphin
FRIEDMANN, DO, Daniel V	Philadelphia
FRIEDRICH, MD, Joachim H	York
FRIEDSAM, MD, Patricia L	Philadelphia
FRIEMAN, MD, Barbara G	Philadelphia
FRIES, MD, Gene T	Lycoming
FRIGNITO, MD, Nicholas G	Philadelphia
FRINK, Richard O	Allegheny
FRISCH, MD, Mark B	Montgomery
FRISHMUTH, MD, Gertrude J	Philadelphia
FRITCHEY JR, MD, John A	Dauphin
FRITCHLEY, MD, Rodney B	Cumberland
FRITZ, MD, Louisa J	Wyoming
FRITZ, MD, William D	Venango
FRITZ JR, MD, Karl J	Warren
FROBESE, MD, Alfred S	Philadelphia
FROEHLICH, MD, Arthur D	Dauphin
FROMAN, MD, Stephen M	Beaver
FROMM, MD, Mitchel L	Lehigh
FROMME, MD, Kenneth L	Dauphin
FRONCZEK, MD, William M	Allegheny
FRONDUTI, MD, Lucian J	Westmoreland
FRONDUTI, MD, Robert L	Allegheny
FROOZAN, MD, Homayoon	Lackawanna
FROST, MD, Albert G	Montgomery
FROST, MD, Stephen S	Philadelphia
FROST JR, MD, William W	Philadelphia
FRUMIN, MD, Abraham M	Philadelphia
FRY, MD, Chloe O	Dauphin
FRY, MD, Robert L	Franklin
FRYCZYNSKI, MD, Thaddeus P	Erie
FRYE, MD, John W	Luzerne
FU, MD, Freddie H	Allegheny
FUCHS, MD, David E	Lancaster
FUERST, MD, Nicholas E	Washington
FUGARO, DO, Anthony J	Montgomery
FUGATE, MD, Howard	Jefferson
FUGATE, MD, James K	Jefferson
FUGATE JR, MD, Howard	Jefferson
FUGAZZOTTO, MD, Pasquale J	Lehigh
FUGE, Ladonna H	Students
FUGO, MD, Richard J	Montgomery
FUHRMAN, MD, Carl R	Allegheny
FUJIMAGARI, MD, Tak	Lawrence
FUKUI, MD, Paul T	Chester
FULCHIERO, MD, Gregory J	Blair
FULCINITI, MD, Rocco A	Allegheny
FULGINITI III, John	Students
FULLER, MD, Garry L	Allegheny
FULLER, MD, Harry B	Delaware
FULLER, MD, Virginia S	Allegheny
FULTON, MD, Harry C	Lancaster
FULTON, MD, William O	York
FUNCH, MD, Ross S	Philadelphia
FUNK JR, MD, Elmer H	Philadelphia
FUNK JR, MD, F Coleman	Lycoming
FUNKE, MD, Alvin H	Columbia
FUNKHOUSER, MD, George R	Montour
FUNKHOUSER, MD, Jay L	Beaver
FUNT, MD, Loren	Allegheny
FUOSS, Mark J	Allegheny
FUREY, MD, Sandy A	Lackawanna
FUREY JR, MD, Charles A	Philadelphia
FURGIUELE, MD, Francis P	Philadelphia
FURGIUELE-IRACKI, MD, Natalie	Allegheny
FURIA, MD, Frederick A	Delaware
FURIA, MD, Robert	Delaware
FURIGAY, MD, R L	Cambria
FURMAN, MD, Donald J	Warren
FURMAN, MD, Harold B	Montgomery
FURNARY, MD, James S	Cambria
FURNER, DO, Carl L	Luzerne
FURR, MD, Charles M	Erie
FURUKAWA, MD, Edward F	Philadelphia
FUSCO, MD, Robert D	Allegheny
FUSCO-RIPKA, MD, Giovanna D	Berks
FUSIA, MD, Joseph F	Allegheny
FUSIA JR, MD, Donald A	Westmoreland
FUST, MD, John A	Erie
FUTCHER, MD, Palmer H	Philadelphia
FUTRELL, MD, J William	Allegheny

G

GAARY, MD, Alvin E	Delaware
GABALA, MD, John M	Northumberland
GABLE, MD, Joseph E	Berks
GABOS, MD, Charles W	Allegheny
GABOS, MD, Paul F	Allegheny
GABRESKI, MD, Robert G	Warren
GABRIEL, MD, Daniel E	Washington
GABRIEL, MD, Frederick R	Mckean
GABRIEL, MD, Larry C	Lawrence
GABRIEL, MD, Peter	Fayette
GABRIEL, MD, Steven A	Lawrence
GABRIELE, MD, August A	York
GABRIELE, MD, Robert L	Venango
GABUZDA, MD, Thomas G	Philadelphia
GADANI, MD, Pravin R	Perry
GADBOIS, MD, William F	Northampton
GADIPARTHI, MD, Atchaiah	Somerset
GAFFNEY, MD, Edmund J	Montgomery
GAFFNEY, MD, John J	Lackawanna
GAFFNEY, MD, Paul C	Allegheny
GAFFORD, MD, Grady D	Tioga
GAGIANAS, Peter J	Allegheny
GAIA, MD, Juan D	Luzerne
GAIN, MD, Thomas B	Philadelphia
GAISFORD, MD, John C	Allegheny
GAITHER, MD, Herbert	Dauphin
GAJULA, MD, L Narayan	Carbon
GALA, MD, Indira H	Philadelphia
GALANIS, MD, Sotire E	Lancaster
GALATI, MD, Victor G	Delaware
GALENA, MD, Harold J	Philadelphia
GALGON, MD, John P	Lehigh
GALIA, MD, Joseph H	Delaware
GALIB, MD, Samuel H	Chester
GALINDO-RODRIGUEZ, MD, Ana I	Montgomery
GALLAGER, MD, James G	Montour
GALLAGHER, MD, Donald I	Delaware
GALLAGHER, MD, Doris B	Montgomery
GALLAGHER, MD, Henry G	Luzerne
GALLAGHER, MD, John E	Armstrong
GALLAGHER, MD, Michael J	Lackawanna
GALLAGHER, MD, Philip E	Allegheny
GALLATI, MD, Michele T	Philadelphia
GALLEN, MD, John H	Berks
GALLETTA, MD, Anthony S	Washington
GALLIA, MD, Francis J	Dauphin
GALLIGAN, MD, William J	Philadelphia
GALOS, MD, Richard S	Allegheny
GALTMAN, MD, Lawrence M	Philadelphia
GALVEZ, MD, Marietta L	Philadelphia
GAMBESCIA, MD, Joseph M	Philadelphia
GAMBESCIA, MD, Richard A	Philadelphia
GAMBETTA, MD, Esmeralda	Philadelphia
GAMBONE, MD, Victor E	Philadelphia
GANDY, DO, Daniel R	Lycoming
GANGLOFF, MD, Michael A	York
GANGULI, MD, Pundalik S	Dauphin
GANIBAN, MD, Justiniano S	Philadelphia
GANIME, MD, Peter D	Montgomery
GANNON, MD, Jeanne E	Allegheny
GANNON, MD, Reynaldo T	Cambria
GANNON, MD, Robert P	Allegheny
GANOTT, MD, Marie A	Allegheny
GANSMAN, MD, David H	Philadelphia
GARABEDIAN, MD, Joseph A	Montgomery
GARBAK, MD, Frank	Philadelphia
GARBER, MD, Edward H	York
GARBER, MD, Mark W	Philadelphia
GARBER, MD, Nancy D	Philadelphia
GARBES, MD, Archimedes D	Montour
GARCIA, MD, Alfredo J	Butler
GARCIA, MD, Antonio S	Berks
GARCIA, MD, Celso R	Philadelphia
GARCIA, MD, Diosdado A	Allegheny
GARCIA, MD, Dominador I	Chester
GARCIA, MD, Domingo A	Franklin
GARCIA, MD, Guillermo	Dauphin
GARCIA, MD, Jose A	Dauphin
GARCIA, MD, Jose C	Philadelphia
GARCIA, MD, Jose R	Lehigh
GARCIA, MD, Laureano P	Philadelphia
GARCIA, MD, Marian	Centre
GARCIA, MD, Theodore A	Montgomery
GARDENER, MD, Ralph	Allegheny
GARDNER, MD, Alan M	Chester
GARDNER, DO, Bonnie J	Philadelphia
GARDNER, MD, George E	York
GARDNER, MD, Harry W	Mifflin / Juniata
GARDNER, MD, James L	Lawrence
GARDNER, DO, Marshall K	Philadelphia
GARDNER, MD, Morris Z	Allegheny
GARDNER, MD, Robert S	Allegheny
GARDNER, MD, Shyrelle	Philadelphia
GARDNER, MD, Thomas A	Venango
GARDNER, MD, Thomas W	Venango
GAREIS, MD, John W	Lancaster
GAREY, MD, Herman S	Lackawanna
GARFIELD, MD, Samuel J	Philadelphia
GARFINKEL, MD, Marc E	Allegheny
GARFINKLE, MD, William B	Philadelphia
GARG, MD, Rekha	Allegheny
GARMAN, MD, Ray F	Bradford
GARNER, MD, Blaine R	Bucks
GARNER, MD, Lois L	Venango
GARNER, MD, William J	Allegheny
GARNET, MD, James D	Philadelphia
GAROFALO, MD, Carl A	Fayette
GAROFOLA, MD, John H	Lancaster
GAROFOLI, MD, Caesar A	Allegheny
GARRAWAY, DO, Wayne S	Delaware
GARRETT, MD, John C	Montour
GARRETT, Kevin O	Allegheny
GARRETT JR, MD, William S	Allegheny
GARRETTSON, MD, James A	Indiana
GARRIDO, MD, Eddy	Lancaster
GARRIOTT, MD, John C	Mercer
GARRISON, MD, John M	Erie
GARROTT, MD, John W	Armstrong
GARSON, MD, Warfield	Allegheny
GARTLAND, MD, John J	Philadelphia
GARTNER, MD, William S	Delaware
GARTNER JR, MD, William S	Delaware
GARVER, MD, Kenneth L	Allegheny
GARVEY, MD, Edmund P	Lancaster
GARVEY, MD, William P	Erie
GARY, MD, Gerald L	Philadelphia
GARZARELLI, MD, David M	Allegheny
GASCON, MD, Perla G	Philadelphia
GASH, MD, Richard M	Philadelphia
GASIOR, MD, Thomas A	Allegheny
GASKILL, Christine R	Students
GASKINS, MD, Albert L	Philadelphia
GASOWSKI, MD, Gary L	York
GASPAR, MD, Victoria S	Philadelphia
GASPARI, MD, Raymond J	York
GASTALDO, MD, John A	Lancaster
GASULL JR, MD, H Robert	Perry
GATES, MD, David M	Allegheny
GATSKI, MD, Robert L	Montour
GATTER, MD, Robert A	Montgomery
GATTI, MD, Dominic L	Montgomery
GATTI, MD, Joseph W	Indiana
GATTO, MD, Frank M	Allegheny
GAUDIO JR, MD, Ralph	Allegheny
GAUDIOSE, MD, Michael C	Franklin
GAUGHAN, MD, Joseph F	Erie
GAUL, MD, James J	Bucks
GAULIN, MD, J Claude	Northampton
GAULT, MD, James H	Lancaster
GAUNTNER, MD, Wallace C	Allegheny
GAUSE, MD, Paul E	Lancaster
GAUSS, MD, William F	Allegheny
GAVIN, MD, George M	Westmoreland
GAVIN, MD, J Robert	Lackawanna
GAWCHIK, DO, Sandra M	Delaware
GAY, MD, Thomas C	Allegheny
GAYDOS, MD, Anna E	Philadelphia
GAYDOS, MD, John D	Beaver
GAYDOS, MD, Thomas L	Northampton
GAYESKI, MD, Richard J	Lancaster
GAYLOR, MD, Donald H	Lehigh
GAYLOR, MD, Theodore H	Lehigh
GAYNOR, MD, William B	Lancaster
GAZAK, MD, Stephen J	Philadelphia
GAZDER, MD, Aftab A	Northumberland
GAZDICK, MD, Mary Anne	Montgomery
GAZEK, MD, Francisco A	Luzerne
GAZMEN, MD, Candonino C	Lackawanna
GAZOWSKI, MD, Thomas E	Luzerne
GEADAH, MD, Fouad A	Dauphin
GEARHART, MD, Lyster M	Lehigh
GECKELER, MD, Edwin O	Philadelphia
GEDEKOH, MD, Robert H	Allegheny
GEDULDIG, MD, Michael M	Dauphin
GEE, MD, William	Lehigh
GEER, MD, Frank D	Lawrence
GEETTER, MD, Philip H	Bucks
GEFTER, MD, Louis P	Philadelphia
GEGWICH, MD, Frank	Columbia
GEGWICH, MD, Joseph F	Columbia
GEHL, MD, Leonard G	Allegheny
GEHL, MD, Richard	Allegheny
GEHMAN, Gary S	Students
GEHMAN, MD, Milton J	Berks
GEHRIS, MD, James C	Northumberland
GEHRIS, MD, John M	Northumberland
GEHRIS, MD, Leroy A	Berks
GEHRON JR, MD, William H	Lycoming
GEIGLE, MD, Carl F	Erie
GEISELMAN, MD, Douglas L	York
GEISER, Bernard T	Allegheny
GEIST, MD, Donald C	Philadelphia
GEITGEY, MD, William I	Blair
GELACEK, MD, Philip A	Armstrong
GELEHRTER, MD, Joseph	Philadelphia
GELET, MD, Theodore R	Allegheny
GELFAND, MD, David	Philadelphia
GELFOND, MD, David B	Philadelphia
GELLER, MD, D Michael	Montgomery
GELLER, MD, Edward I	Lehigh
GELLER, MD, Joseph	Philadelphia
GELLER, MD, Mark J	Allegheny
GELLER, MD, Michael H	Lehigh
GELLER, MD, Robert B	Philadelphia
GELMAN, MD, Ricardo	Philadelphia
GEMIL, MD, Corazon G	Chester
GEMMILL, MD, Reginald B	York
GENATO, MD, Jaime M	Westmoreland
GENC, MD, Salim	Mifflin / Juniata
GENDELL, MD, Howard M	Allegheny
GENERALOVICH, MD, Thomas	Allegheny
GENERETTE, MD, William O	Allegheny
GENNARELLI, MD, Thomas A	Philadelphia
GENNARIA, MD, C Reed	Northumberland
GENNARO, MD, Anthony R	Philadelphia
GENOVESE, MD, Frank N	Armstrong
GENT, MD, Joseph A	Venango
GENTER, MD, Bruce E	Philadelphia
GENTILE, MD, Anthony J	Lackawanna
GENTZLER II, MD, Richard D	Lancaster
GEORGE, MD, David L	Berks
GEORGE, MD, Ellen M	Lancaster
GEORGE, MD, Jacob	Erie
GEORGE, MD, James M	Allegheny
GEORGE, MD, John J	Allegheny
GEORGE, MD, Jose P	Allegheny
GEORGE, MD, Paula	Berks
GEORGE, MD, Robert A	Allegheny
GEORGE, MD, Robert B	Franklin
GEORGE, MD, Robert N	Allegheny
GEORGETSON, Michael J	Students
GEORGIU, MD, Virgil	Lackawanna
GEORGY, MD, Farouk M	Lycoming
GERARD, MD, Joseph A	Allegheny
GERBER, MD, Donald S	Philadelphia
GERBER, MD, Harris S	Philadelphia
GERBER, MD, Michael L	Allegheny
GERBER, MD, Paul	Philadelphia
GERCHMAN, MD, Leroy B	Lehigh
GERDES, MD, Jeffrey S	Philadelphia
GERDES JR, MD, Joseph H	Dauphin
GERFIN, MD, Ernest R	Wyoming
GERGEN, MD, Werner A	Bradford
GERGER, MD, Joseph P	Westmoreland
GERHART, MD, George R	Berks
GERIG, MD, John S	Montour

GERLACH, MD, Detlef H	York
GERMAN, MD, Antonio I	Erie
GERMAN, MD, Terry M	Montgomery
GERMER, MD, Bruce A	Philadelphia
GERNETH, MD, George J	Allegheny
GERONIMO, MD, Lauro S	Northampton
GERSHENFELD, MD, Marvin A	Philadelphia
GERSHKOFF, MD, Arthur M	Philadelphia
GERSHON, DO, Justin H	Montgomery
GERSON, MD, Irvin M	Montgomery
GERSON, MD, Leroy T	Delaware
GERSTBREIN, MD, Harry L	Armstrong
GERSTLEY III, MD, Louis	Philadelphia
GERSTMAN, MD, Ira	Montgomery
GESSEL, MD, Arnold H	Delaware
GESSNER, MD, Thomas P	Westmoreland
GESSNER, MD, Victoria A	Philadelphia
GETTE, Michael T	Students
GETTE, MD, Warren A	Franklin
GETZ, DO, Harry D	Bucks
GETZ, MD, William B	Philadelphia
GEVER, MD, Harold K	Bucks
GEVJAN, MD, Armen H	Delaware
GHATAK, MD, Peter K	Northampton
GHATE, MD, Sharad B	Indiana
GHATNEKAR, MD, Jai V	Allegheny
GHIA, MD, Pradeep S	Northampton
GHOSH, MD, Bijoy K	Philadelphia
GHOSH, MD, Suresh C	Philadelphia
GHOSH, MD, Tarit K	Montour
GHOSHHAJRA, MD, Kalyanmay	Allegheny
GIACCIA, MD, Amato	Berks
GIALAMAS, MD, Antonio	Allegheny
GIAM, MD, Patrick Y	Philadelphia
GIAMPETRO, MD, Anthony M	Philadelphia
GIANAKON, MD, Harry G	Philadelphia
GIANFAGNA, MD, William J	Schuylkill
GIANNASIO, MD, Charles V	Montgomery
GIANNOPOULOS, MD, Peter H	Chester
GIARDINO, Angelo P	Students
GIBBLE, MD, Leon W	York
GIBBONS, MD, Richard E	Philadelphia
GIBBONS, MD, Robert J	Luzerne
GIBBONS, MD, William P	Blair
GIBBS, MD, Winfield S	Northumberland
GIBSON, MD, F Clay	Westmoreland
GIBSON, MD, William B	Delaware
GIBSON, MD, William E	Allegheny
GIBSON, MD, William S	Allegheny
GIBSON, MD, William S	Montour
GIBSON JR, MD, Roy L	Allegheny
GIERING, MD, John F	Luzerne
GIESECKE, MD, Susan B	Berks
GIGLIOTTI, MD, Anthony C	Philadelphia
GILARSKY, MD, Bruce P	Philadelphia
GILBERT, DO, Max	Philadelphia
GILBERT, MD, Robert P	Philadelphia
GILBERTI, MD, Frank F	Allegheny
GILBERTI, MD, Michael V	Allegheny
GILDEA, MD, James E	Dauphin
GILFILLAN, MD, A George	Berks
GILFORD, MD, Lawrence M	Clarion
GILGORE, MD, Gary S	Philadelphia
GILL, MD, Donald J	Philadelphia
GILL, MD, John J	Luzerne
GILL, MD, Robert J	Philadelphia
GILL III, MD, Thomas J	Allegheny
GILLAN, MD, Ernest F	Montgomery
GILLEN, MD, Dennis R	Bucks
GILLEN, MD, George P	Northampton
GILLEN, William S	Students
GILLESPIE, MD, Harry K	Westmoreland
GILLESPY, Mark C	Students
GILLESPY, MD, William G	Lawrence
GILLIGAN, MD, Frank P	Delaware
GILLIS, MD, Victoria A	Armstrong
GILLUM, MD, David F	Tioga
GILMAN, MD, Edward	Allegheny
GILMAN, MD, Paul B	Philadelphia
GILMORE, MD, Frederick R	Clearfield
GILMORE, MD, George H	Allegheny
GILMORE, MD, Ina M	Jefferson
GILMORE, MD, Irvin W	Berks
GILMORE, MD, James	Allegheny
GILMORE JR, MD, Hugh R	Delaware
GILOT, MD, Jean M	Blair
GILROY, Anne F	Students
GILROY, MD, Robert C	Dauphin
GINCHEREAU, MD, Eugene H	Allegheny
GINDE, MD, Ravindra V	Bucks
GINGRICH, MD, Kerry H	Lebanon
GINGRICH, MD, Kevin J	Allegheny
GINGRICH JR, MD, Russell L	Lebanon
GINIECZKI, MD, Chester J	Philadelphia
GINLEY JR, MD, Thomas H	Philadelphia
GINSBERG, MD, David K	Philadelphia
GINSBERG, MD, Gene H	Lehigh
GINSBERG, MD, Joseph E	Lawrence
GINSBURG, MD, Abraham	Philadelphia
GINSBURG, David L	Allegheny
GINSBURG, MD, David S	Delaware
GINSBURG, MD, Howard H	Philadelphia
GINSBURG, MD, Isadore W	Philadelphia
GINSBURG, MD, John L	Union
GINSBURG, MD, Michael J	Allegheny
GINSBURG, MD, Nathan N	Lawrence
GINSBURG, MD, Silas J	Montgomery
GINTER JR, MD, George C	Lycoming
GIOMBETTI, MD, Joseph J	Lackawanna
GIORDANO, MD, Augustin T	Philadelphia
GIORDANO, MD, Lorraine M	Philadelphia
GIORDANO, MD, Nicholas D	Luzerne
GIPSON, MD, Lawrence L	Allegheny
GIRARDO, MD, Salvatore P	Philadelphia
GIRDANY, MD, Bertram R	Allegheny
GIRDANY, MD, David S	Allegheny
GIRONE, MD, Joseph A	Bucks
GIRONE, MD, Joseph F	Philadelphia
GIRSH, MD, Leonard S	Philadelphia
GISLASON, MD, G John	Philadelphia
GITLIN, MD, Melvin C	Montgomery
GITTINGS, MD, Paul E	Allegheny
GITTLEMAN, MD, Mark A	Lehigh
GIUDICE, MD, Virginio J	Philadelphia
GIUFFRE, MD, Adrienne M	Philadelphia
GIUFFRE, MD, James C	Philadelphia
GIUGLIANO, MD, Frank J	Columbia
GIULIAN, MD, Bertrand B	Dauphin
GIULIAN, MD, Karl A	Philadelphia
GIUNTOLI, MD, Robert L	Philadelphia
GIVEN, MD, Kenneth M	Philadelphia
GIVENS, MD, Frederick T	Dauphin
GIVLER JR, MD, Donald N	Lancaster
GLACKEN, MD, Michael F	Philadelphia
GLADSTONE, MD, Julian L	Delaware
GLAH JR, MD, Henry J	Lancaster
GLANZBERG, MD, Pauline	Montgomery
GLASER, MD, Barry L	Montgomery
GLASKIN, MD, Allen	Philadelphia
GLASS, MD, Gary M	Philadelphia
GLASS, MD, Phillip	Philadelphia
GLASS, MD, Steven J	Philadelphia
GLASSBURN, MD, Edward M	Allegheny
GLASSBURN, MD, John R	Philadelphia
GLASSER, MD, Stuart A	Westmoreland
GLASSMAN, MD, Joel M	Philadelphia
GLASSMAN, MD, Solomon	Philadelphia
GLASSNER, MD, Michael J	Philadelphia
GLASSO, MD, Louis C	Allegheny
GLATZ, Guy G	Students
GLAUSER, MD, Felix E	Dauphin
GLAZER, MD, Robert M	Philadelphia
GLAZERMAN, MD, Larry R	Lehigh
GLAZMAN, MD, Lyudmila	Philadelphia
GLEASON, MD, James A	Allegheny
GLEESON, MD, George H	Allegheny
GLEESON, MD, George L	Dauphin
GLENN, MD, John F	Washington
GLENNEY, MD, Wilton	Schuylkill
GLENNON, MD, Joseph A	Philadelphia
GLICK, MD, Abraham	Philadelphia
GLICK, MD, Harold M	Allegheny
GLICK, MD, Kenneth A	Allegheny
GLICK, MD, Ronald M	Allegheny
GLORIOSO, MD, Joseph J	Allegheny
GLOSSER, MD, William E	Berks
GLOWACKI, MD, Francis L	Venango
GLUCK, MD, Michael L	Cumberland
GLUCKMAN, MD, Stephen J	Philadelphia
GLUECK, MD, David G	Lehigh
GMUER, MD, Paul J	Erie
GNEGY, MD, Richard	Allegheny
GO, MD, Alfonzo H L	Lycoming
GO, MD, Josephine L	Delaware
GO, MD, Welles P	Philadelphia
GO JR, MD, William C	Cambria
GOBEL, MD, Reginald T	York
GOCHOCO, MD, Jacinto J	York
GODDARD JR, MD, James E	Lancaster
GODFREY, DO, Craig R	Crawford
GODINEZ-CEJUDO, MD, Jorge A	Philadelphia
GODLA, MD, Gregory J	Allegheny
GODSHALL, MD, Richard W	Bucks
GODSHALL, MD, Stanley M	Lancaster
GOEBERT, MD, Herbert W	Chester
GOEDECKE, MD, John B	Dauphin
GOEHRING, MD, Donald E	Butler
GOEHRING, MD, Walter O	Allegheny
GOEL, MD, Inder P	Philadelphia
GOELTSCH, MD, Robert E	Dauphin
GOEPP, MD, Carla E	Philadelphia
GOERINGER, MD, C Fred	Montgomery
GOESER, MD, Eugene	Delaware
GOESSLER, MD, Mary C	Allegheny
GOGGIN, MD, Leon D	Beaver
GOHEL, MD, Vijaysinh K	Philadelphia
GOKHALE, MD, Sudhir B	Erie
GOLANI, MD, Umesh A	Allegheny
GOLD, MD, Allan	Philadelphia
GOLD, MD, Arnold Z	Venango
GOLD, MD, Barbara W	Philadelphia
GOLD, MD, Gordon R	Allegheny
GOLD, MD, Henry J	Philadelphia
GOLD, MD, Herman	Delaware
GOLD, MD, Jack	Erie
GOLD, MD, Jerome A	Philadelphia
GOLD, MD, Morrie G	Chester
GOLDBACHER JR, MD, Lawrence R	Philadelphia
GOLDBERG, MD, Alan H	Montgomery
GOLDBERG, MD, Andrew G	Philadelphia
GOLDBERG, MD, Barry B	Philadelphia
GOLDBERG, MD, Gary	Philadelphia
GOLDBERG, MD, Harry	Philadelphia
GOLDBERG, MD, Harvey E	Bucks
GOLDBERG, MD, Larry H	Philadelphia
GOLDBERG, MD, Lisa A	Allegheny
GOLDBERG, MD, Louis	Montgomery
GOLDBERG, MD, Marc B	Philadelphia
GOLDBERG, DO, Murray	Philadelphia
GOLDBERG, DO, Murray E	Chester
GOLDBERG, MD, Richard E	Philadelphia
GOLDBERG, MD, Richard M	Montour
GOLDBERG, MD, Sheldon	Philadelphia
GOLDBERG, MD, Steven E	Philadelphia
GOLDBERG, MD, Steven K	Philadelphia
GOLDBERG, MD, Todd H	Philadelphia
GOLDBERGER, MD, Arnold	Philadelphia
GOLDBLATT, MD, Sidney A	Cambria
GOLDBLUM, MD, Abraham D	Allegheny
GOLDBLUM, MD, Jacob	Fayette
GOLDBLUM, MD, Lee J	Allegheny
GOLDBLUM, MD, Orin M	Allegheny
GOLDBLUM, MD, Raymond W	Allegheny
GOLDBURGH, MD, Warren P	Philadelphia
GOLDEN, MD, Jean D	Monroe
GOLDEN, MD, Mano R	Montgomery
GOLDEN, MD, Michael F	Chester
GOLDEN IV, MD, Samuel W	Allegheny
GOLDENBERG, MD, Arnold	Chester
GOLDENER, MD, John F	Montgomery
GOLDFARB, MD, Alvin F	Philadelphia
GOLDFARB, MD, Daniel D	Lehigh
GOLDFARB, MD, Harold J	Lehigh
GOLDFARB, MD, I William	Allegheny
GOLDFARB, MD, Lloyd G	Lancaster
GOLDFEDER, MD, Warren J	Bucks
GOLDFINE, MD, Alan	Chester
GOLDFINE, MD, Harry A	Philadelphia
GOLDFINE, MD, Joseph D	Philadelphia
GOLDIN, MD, Ralph J	Lancaster
GOLDING, MD, Irvin M	Allegheny
GOLDMAN, MD, Arthur	Delaware
GOLDMAN, MD, Arthur J	Philadelphia
GOLDMAN, MD, Duane C	Lancaster
GOLDMAN, Gary A	Students
GOLDMAN, MD, Gary L	Lancaster
GOLDMAN, MD, H Warren	Philadelphia
GOLDMAN, MD, Irving S	Allegheny
GOLDMAN, L Barton	Students
GOLDMAN, MD, Marvin	Philadelphia
GOLDMAN, MD, Richard J	Delaware
GOLDMAN, MD, Robert F	Franklin
GOLDMAN, MD, Scott M	Philadelphia
GOLDMAN, MD, Stanley R	Dauphin
GOLDSCHMIDT, MD, Herbert	Montgomery
GOLDSCHMIDT, MD, Pauline	Blair
GOLDSMITH, MD, Charles P	Lehigh
GOLDSTEIN, MD, Arnold L	Bucks
GOLDSTEIN, MD, Arthur M	Philadelphia
GOLDSTEIN, MD, Bernard	Philadelphia
GOLDSTEIN, MD, Elliott J	Allegheny
GOLDSTEIN, MD, Erroll J	Lackawanna
GOLDSTEIN, MD, Franz	Philadelphia
GOLDSTEIN, MD, Irwin S	Philadelphia
GOLDSTEIN, MD, Jacob	Philadelphia
GOLDSTEIN, MD, Jerome	Philadelphia
GOLDSTEIN, MD, Jerome B	Delaware
GOLDSTEIN, MD, Larry E	Philadelphia
GOLDSTEIN, MD, Laurence	Dauphin
GOLDSTEIN, MD, Milton J	Lackawanna
GOLDSTEIN, MD, Morton L	Allegheny
GOLDSTEIN, MD, Neil H	Chester
GOLDSTEIN, MD, Norman A	Chester
GOLDSTEIN, MD, Norman S	Philadelphia
GOLDSTEIN, MD, Robert C	Philadelphia
GOLDSTEIN, MD, Scott D	Philadelphia
GOLDSTONE, MD, Harry A	Washington
GOLDSTONE, MD, Sheldon B	Lackawanna
GOLDSTROHM, MD, Robert G	Indiana
GOLDWEIN, MD, Manfred I	Philadelphia
GOLER, MD, K Andrew	Montour
GOLLA, MD, Chandra S	Allegheny
GOLLA, MD, Saraswathi K	Allegheny
GOLLATZ, MD, John W	Allegheny
GOLLUB, MD, Morton J	Philadelphia
GOLOMB, MD, Milton W	Allegheny
GOLOMB, MD, Norman G	Washington
GOLTZ, MD, Gerald M	Allegheny
GOLUB, MD, Michael S	Philadelphia
GOMAR, MD, Alfonso A	Lackawanna
GOMBAR, MD, Edward F	Lackawanna
GOMBERG, MD, Jack A	Philadelphia
GOMEZ, MD, Blanca M	Montgomery
GOMEZ, MD, Luis L	Crawford
GOMEZ, MD, Pedro F	Montgomery
GONICK, MD, Paul	Philadelphia
GONNELLA, MD, Joseph S	Philadelphia
GONZALES, MD, Albert	Bucks
GONZALEZ, MD, Alejandro R	Allegheny
GONZALEZ, MD, Carlos	Philadelphia
GONZALEZ, MD, Dominic E	Montgomery
GONZALEZ, MD, Rene M	Philadelphia
GONZALEZ, MD, Roberta B	Philadelphia
GONZALEZ-MASO, MD, George E	Philadelphia
GOOD, MD, Chester B	Allegheny
GOOD, MD, Daniel C	Lancaster
GOOD, MD, Harry S	Lehigh
GOOD, MD, Milton S	Lancaster
GOOD, MD, R Duane	Crawford
GOOD, MD, Robert F	Allegheny
GOOD, MD, Robert P	Montgomery
GOOD, MD, Vance A	Bradford
GOODMAN, MD, Bruce	Dauphin
GOODMAN, MD, Carl R	Montgomery
GOODMAN, MD, David B	Fayette
GOODMAN, DO, Donald A	Philadelphia
GOODMAN, MD, Doris	Philadelphia
GOODMAN, MD, Gerald A	Berks
GOODMAN, Gordon T	Allegheny
GOODMAN, MD, Mark A	Allegheny
GOODMAN, MD, Richard A	Allegheny
GOODMAN, MD, Robert L	Philadelphia
GOODMAN, MD, Sanford M	Montgomery
GOODMAN, MD, William H	Delaware
GOODNER, MD, David M	Philadelphia
GOODPASTOR, MD, William E	Allegheny
GOODREAU, MD, James J	Lehigh
GOODRICH, MD, David C	Northampton
GOODRICH, MD, Jack K	Erie
GOODRICH, MD, Kenneth B	Allegheny
GOODRICH, MD, Steven D	Philadelphia
GOODWORTH, MD, John H	Allegheny
GOODYEAR, MD, James A	Montgomery
GOOSENBERG, MD, Eric B	Philadelphia
GOPAL, MD, Krishnan A	Allegheny
GOPLERUD, MD, Elizabeth J	Carbon
GOPPALD, MD, Ronald Wm	Bucks
GOPPELT, MD, John W	Montgomery
GORAB II, Robert S	Allegheny
GORACCI, MD, Armando	Philadelphia
GORACCI, Grace G	Students
GORALCZYK JR, MD, Edward J	Allegheny
GORAN, MD, Daniel D	Berks
GORBY, MD, Charles K	Delaware
GORDEUK, MD, Daniel S	Centre
GORDIN, MD, Stephen J	Philadelphia
GORDNER JR, MD, Jesse W	Montour
GORDON, MD, Alan D	Mifflin/Juniata
GORDON, MD, Arthur E	Montgomery
GORDON, MD, Barry M	Allegheny
GORDON, MD, Brian L	Philadelphia
GORDON, MD, Burgess L	Philadelphia
GORDON, MD, Charles A	Lehigh
GORDON, DO, Daniel S	Jefferson
GORDON, David A	Students
GORDON, MD, Dudley R	Dauphin
GORDON, MD, Elizabeth H	Allegheny
GORDON, MD, Gerald	Montour
GORDON, MD, Harold E	Westmoreland
GORDON, MD, Isadore	Chester
GORDON, MD, Jacob S	Philadelphia
GORDON, MD, James K	Bedford
GORDON, MD, Jerold S	Allegheny
GORDON, MD, Joseph S	Delaware
GORDON, MD, Keith L	Philadelphia
GORDON, MD, Lawrence A	Montgomery
GORDON, MD, Leonard F	Montgomery
GORDON, MD, Michael E	Berks
GORDON, MD, Michael J	Lehigh
GORDON, MD, Milton S	Westmoreland
GORDON, MD, Murray B	Allegheny
GORDON, MD, Richard S	Allegheny
GORDON, MD, Robert A	Lebanon
GORDON, MD, Robert H	Philadelphia
GORDON, DO, Sanford A	Washington
GORDON, MD, Susan J	Philadelphia
GORDON, MD, Tom J	Allegheny
GORDON, MD, William S	Dauphin
GORDON JR, MD, Kenneth H	Montgomery
GOREN, MD, Elihu N	Montgomery
GOREN, MD, Lawrence J	Philadelphia
GOREN, MD, Robert A	Philadelphia
GOREN, MD, Ronald C	Philadelphia
GOREN, MD, Stanley E	Philadelphia
GORRY, MD, John D	Delaware
GORSKI, MD, Eugene D	Luzerne
GORSUCH, MD, Paul L	Philadelphia
GOSFIELD JR, MD, Edward	Philadelphia
GOSHORN, MD, Roy W	Blair
GOSZTONYI JR, MD, Rudolph E	Northampton
GOTLIEB, MD, Jerry	Montgomery
GOTTFRIED, MD, Irving S	Allegheny
GOTTHEIL, MD, Edward	Philadelphia
GOTTLIEB, MD, Harry	Philadelphia
GOTTLIEB, MD, Jerome I	Lancaster
GOTTLIEB, DO, Marshall M	Philadelphia
GOTTLIEB, MD, Philip M	Philadelphia
GOTTLIEB, MD, Robert J	Lancaster
GOTTLIEB, MD, Ronald S	Philadelphia
GOTTLIEB, MD, Stanley	Philadelphia
GOTTSHALL, MD, Samuel C	Lackawanna
GOUGER, MD, Dale B	Berks
GOULD, MD, Richard B	Philadelphia
GOULDIN, MD, Judith A	Lycoming
GOULEY, MD, Benjamin A	Philadelphia
GOURASH, MD, Leona	Allegheny
GOUW, MD, Christopher B	Carbon
GOVER, MD, Charles L	Centre
GOWDEY, MD, M Agnes	Philadelphia
GOWEN, MD, George F	Montgomery
GOWING, MD, Jean	Philadelphia
GOYAL, MD, Suman	Philadelphia
GOYNE, MD, Ruth G	Delaware
GOZUM, MD, Carmen Z	Northampton
GRAB, MD, Edmundo M	Blair
GRABIAK, MD, Gregory D	Westmoreland
GRABIAS, MD, Stanley L	Berks
GRABOWSKI, MD, Marie A	Luzerne
GRABOYES, MD, Arnold B	Lycoming
GRACE, MD, Helen K	Philadelphia
GRACE, MD, James J	Susquehanna
GRACEY, MD, Jack G	York
GRAD, MD, Charles T	Lackawanna
GRAD, MD, L Christine	Philadelphia
GRADY, MD, James W	Cambria

GRAF, MD, Kenneth W Dauphin
GRAFF, MD, Charles K Westmoreland
GRAFT, MD, David F Allegheny
GRAHAM, MD, Barry E Berks
GRAHAM, MD, Garth K Philadelphia
GRAHAM, MD, Joseph E York
GRAHAM, MD, Mark G Philadelphia
GRAHAM, MD, Thomas R Allegheny
GRAHAM III, MD, William P Cumberland
GRAHAM JR, MD, Galen E Erie
GRAJEWSKI, MD, Robert S Erie
GRAMMES, MD, Charles F Montour
GRANA, MD, Philip C Bedford
GRANA, MD, Vicente P Philadelphia
GRANADOS, MD, Nicanor G Berks
GRANADOS, MD, Suzita N Berks
GRANDON, MD, Raymond C Dauphin
GRANICK, MD, Mark S Allegheny
GRANING, MD, George E York
GRANOWITZ, MD, Samuel P Allegheny
GRANSON, MD, Marc A Northampton
GRANT, MD, Alfred A Warren
GRANT, MD, Alistair M Lancaster
GRANT, MD, B David Delaware
GRANT, MD, Kathleen J Allegheny
GRANT, DO, Robert Philadelphia
GRASMICK, MD, Albert L Adams
GRASSE JR, MD, John M Lancaster
GRASSI, MD, Joseph J Lehigh
GRASSI, MD, Michael O Philadelphia
GRATCH, MD, Michael J Montgomery
GRATZ, DO, Irwin Philadelphia
GRATZ, MD, Richard E Lackawanna
GRAU, MD, Keith E Philadelphia
GRAUBARD, MD, Howard M Berks
GRAUDUSIUS, MD, Ruta T Philadelphia
GRAUEL JR, MD, Theodore A Lawrence
GRAVES, MD, Vaughan C Philadelphia
GRAVES JR, MD, Beverly Philadelphia
GRAY, MD, Cynthia A Allegheny
GRAY, MD, David W Union
GRAY, MD, Dennis C Philadelphia
GRAY, MD, Frieda G Philadelphia
GRAY, MD, Herbert M Beaver
GRAY, MD, Jerry L Cambria
GRAY, DO, John M Northampton
GRAY, MD, Louis P Lancaster
GRAY, MD, Robert T Franklin
GRAY III, MD, Samuel Allegheny
GRAY JR, MD, Frank D Philadelphia
GRAY JR, MD, George H Allegheny
GREBER, DO, A Alvin Philadelphia
GRECO, MD, Frank D Allegheny
GRECO, MD, Jeffrey M Montour
GRECO, MD, Jonathan P Philadelphia
GRECO, MD, Joseph F Northumberland
GRECO, MD, Toby A Philadelphia
GRECO, MD, Victor F Luzerne
GREEN, MD, Arthur H Beaver
GREEN, MD, Barry P Montgomery
GREEN, MD, Billie E Philadelphia
GREEN, MD, Bradford Bucks
GREEN, MD, Charles Schuylkill
GREEN, MD, David P Philadelphia
GREEN, MD, George R Montgomery
GREEN, James M Allegheny
GREEN, MD, Joseph E Cumberland
GREEN, MD, Lawrence Delaware
GREEN, MD, Leland J Montgomery
GREEN, MD, M Edwin Dauphin
GREEN, MD, Mary H Allegheny
GREEN, MD, Mayer A Allegheny
GREEN, MD, Richard L Allegheny
GREEN, MD, Robert L Philadelphia
GREEN, MD, Robert M Allegheny
GREEN, MD, Roy Schuylkill
GREEN, MD, Russell P Bucks
GREEN, MD, Thomas J Cumberland
GREEN, MD, William Philadelphia
GREEN, MD, William H Delaware
GREEN 3RD, MD, Joseph E Cumberland
GREEN JR, MD, William T Allegheny
GREENACRE, MD, Judith K Philadelphia
GREENAWALD, MD, Henry A Dauphin
GREENAWALT, MD, Robert G Franklin
GREENBAUM, MD, Charles H Philadelphia
GREENBAUM, MD, James K Armstrong
GREENBAUM, MD, Marvin H Montgomery
GREENBERG, MD, Andrew A Luzerne
GREENBERG, MD, Harry H Philadelphia
GREENBERG, MD, Jack O Philadelphia
GREENBERG, MD, Leonard F Philadelphia
GREENBERG, MD, Marvin S Philadelphia
GREENBERG, MD, Michael R Clinton
GREENBERG, MD, Richard E Montgomery
GREENBERG, MD, Richard H Philadelphia
GREENBERG, MD, Richard M Philadelphia
GREENBERG, MD, Robert N Berks
GREENBERG, MD, Sigmund R Montgomery
GREENBERG, MD, Steven M Jefferson
GREENBERG, MD, Wayne V Allegheny
GREENBURG, MD, Morren J Mercer
GREENE, MD, Donald H Lycoming
GREENE, MD, Gary S Delaware
GREENE, MD, Lucille T Berks
GREENE, MD, Marguerite W Chester
GREENE, MD, Michael H Allegheny
GREENE, MD, Neil A Lancaster
GREENE, MD, Robert F Indiana
GREENE, MD, Ronald B Philadelphia
GREENE, MD, Thomas E Montgomery
GREENFIELD, MD, Lawrence S Montour
GREENFIELD, MD, Samuel L Philadelphia
GREENFIELD, MD, Val S Philadelphia
GREENLEE, MD, Daniel P Greene
GREENLEE, MD, Samuel Allegheny
GREENSPAN, MD, Herbert S Montgomery
GREENSPAN, MD, Mitchell M Bucks
GREENSPON, MD, Arnold J Philadelphia
GREENSPON, MD, Samuel E Montgomery
GREENSTEIN, MD, Sidney Philadelphia
GREENWALD, MD, David W Luzerne
GREENWALD, MD, Stanley M Philadelphia
GREENWOOD, MD, Steven M Montour
GREER, MD, Benjamin J Luzerne
GREER, Diane C Allegheny
GREER III, MD, Robert B Dauphin
GREGERSEN, MD, James O Philadelphia
GREGG, MD, Frank J Allegheny
GREGG, MD, Grace S Allegheny
GREGG, MD, John R Philadelphia
GREGG, MD, John S Allegheny
GREGG, MD, Thomas S Butler
GREGO, MD, J Gregory Allegheny
GREGORY, MD, Daniel H Allegheny
GREGORY, MD, George W Berks
GREGORY, MD, Robert E Allegheny
GREISSINGER, MD, Walter M Allegheny
GRENNAN JR, M Joseph Allegheny
GRENVIK, MD, Ake N Allegheny
GRESS, MD, Francis A Northampton
GRESS, MD, Gordon A Cambria
GRESS, MD, William W Cambria
GRESSLY, MD, Donald W Beaver
GRETH, MD, Warren E Berks
GREYBUSH, MD, Joseph N Lehigh
GRIBB, J Jeffrey Allegheny
GRIBB, MD, John J Bucks
GRIBB, MD, Joseph C Dauphin
GRIBETZ, MD, Michael D Schuylkill
GRIBIK, MD, Joseph J Butler
GRIBIK, MD, Michael Allegheny
GRIEB, MD, Deborah A Philadelphia
GRIECO, William M Students
GRIESMER, MD, Paul D Luzerne
GRIESS, MD, Alfred H Centre
GRIFF, MD, Leonard C Dauphin
GRIFF, MD, Roberta E Dauphin
GRIFFEN, MD, Helen S Venango
GRIFFEN, MD, R Howard Venango
GRIFFIN, MD, Percy W Beaver
GRIFFIN, MD, Steven P Indiana
GRIFFITH, MD, Annette Y Bucks
GRIFFITH, MD, Bartley P Allegheny
GRIFFITH, MD, Charles Q Philadelphia
GRIFFITH, MD, Glenn G Cambria
GRIFFITH, MD, John R Philadelphia
GRIFFITH, MD, Joseph B Allegheny
GRIFFITHS, MD, Charles W Bedford
GRILL, MD, Winfred E Jefferson
GRIM, MD, Mark D Berks
GRIMES, MD, Clarence W Greene
GRISKA, MD, Joel A Philadelphia
GRISWOLD, MD, Arthur S Lancaster
GROFE, MD, Jerrold G Philadelphia
GROFF, MD, Gerald D Lehigh
GROFF, MD, Henry C Allegheny
GROH, MD, John R Lebanon
GROH, MD, William C Berks
GROHSMAN, MD, Jonathan M Montgomery
GROLL, MD, Michael Montgomery
GROLMAN, MD, Dennis M York
GROSH, MD, John L Lancaster
GROSH, MD, Joseph W Lancaster
GROSH, MD, Julieta D Philadelphia
GROSH, MD, Paul R Lancaster
GROSH, MD, William B Lancaster
GROSH, MD, William K Lancaster
GROSKY, MD, Murray B Lebanon
GROSS, MD, Benjamin A Philadelphia
GROSS, MD, Daniel J Montgomery
GROSS, MD, Donald R York
GROSS, MD, Ellen A Philadelphia
GROSS, MD, George W Dauphin
GROSS, MD, Lawrence S Berks
GROSS, MD, Maurice D Montgomery
GROSS, MD, Mitchell J Philadelphia
GROSS, MD, Paul Allegheny
GROSS, MD, Paul R Philadelphia
GROSS, MD, Richard H Chester
GROSSMAN, MD, Alan R Montgomery
GROSSMAN, MD, Eric J Philadelphia
GROSSMAN, MD, Gilbert Philadelphia
GROSSMAN, MD, Ira C Luzerne
GROSSMAN, MD, Joseph N Philadelphia
GROSSMAN, MD, Larry B York
GROSSMAN, MD, Monte S Delaware
GROSSMAN, MD, Perry Chester
GROSSMAN, MD, Ronald M Dauphin
GROSSMAN, Sheila S Students
GROSSMAN JR, MD, Louis W Lawrence
GROTZINGER, MD, Paul J Philadelphia
GROVE, MD, Bruce A York
GROVE, MD, Russell E York
GROVE, MD, William K York
GROVE JR, MD, Dale A Northampton
GROVER, MD, Joseph G Philadelphia
GROVER, MD, Sukhdev S Allegheny
GRUBB, MD, Robert A Northumberland
GRUBB, MD, Willard Y Berks
GRUBBS, MD, Robert M Allegheny
GRUBER, MD, John W Berks
GRUEN, MD, Gary S Philadelphia
GRUMET, MD, Bernard A Allegheny
GRUNBERG, MD, Robert W Lehigh
GRUNT, MD, Richard F Philadelphia
GRUSZKA, MD, Francis A Monroe
GRYCZKO, MD, Gerald A Lackawanna
GSCHWEND III, MD, Paul Lancaster
GU, MD, Jeng Y Bradford
GUAGLIARDO, DO, Joseph P Bucks
GUANZON, MD, Danilo L Crawford
GUARINI, MD, Pasquale B Delaware
GUCKERT, Karen A Allegheny
GUEHL, MD, John J Allegheny
GUEHL, DO, John J Allegheny
GUELCHER, MD, Robert T Erie
GUENTER, MD, Fritz E Mckean
GUERRA, MD, Angel Philadelphia
GUERRERO, MD, Juan R Philadelphia
GUESON, MD, Emerita T Philadelphia
GUESS, MD, Harry A Montgomery
GUILLARD, MD, Frank Centre
GUINTO, MD, Jose C Allegheny
GUIRGUIS, MD, Morris F Delaware
GUIRNALDA-CASTRO, MD, Nemesia G Montgomery
GUISER, MD, Lynn G Mifflin/Juniata
GUISTWITE, MD, Kenneth R Cumberland
GULARSKI, MD, Alice S Allegheny
GULICK, MD, Thomas H Monroe
GULLOTTI, MD, Michael J Philadelphia
GUMER, MD, Arthur Philadelphia
GUMERMAN, MD, Lewis W Allegheny
GUMINA, MD, Thomas F Delaware
GUMNIT, MD, Robert Y Philadelphia
GUMP, MD, Robert B Allegheny
GUNDERSON, MD, Robert L Luzerne
GUNNET, MD, Oren W York
GUNSTER, MD, Gerald D Luzerne
GUNTUR, MD, Sivarama K Allegheny
GUPTA, MD, Chitra L Philadelphia
GUPTA, MD, Giriwarlal Monroe
GUPTA, MD, Krishna G Westmoreland
GUPTA, MD, Mahesh C Bucks
GUPTA, Santosh Students
GUPTA, MD, Sarv K Warren
GUPTA, MD, Ved P Philadelphia
GUPTA, MD, Vinodini Warren
GUREGHIAN, MD, Patricia A Montgomery
GURGUN, MD, Melih Allegheny
GURKAYNAK, MD, Necmi Philadelphia
GURSON, MD, Helen W Allegheny
GUSHUE, DO, George F Bucks
GUSTAINIS, MD, George J Wayne/Pike
GUSTAITIS, MD, Joseph A Lackawanna
GUSTAVSON, MD, Roger B Dauphin
GUSTIN, MD, Thomas A Erie
GUTEKUNST, MD, Paul E Philadelphia
GUTHLEBEN, MD, John G Erie
GUTHRIE, MD, Marshall B Montgomery
GUTHRIE, MD, Michael A Allegheny
GUTHRIE, MD, William J Montgomery
GUTIERREZ, MD, Emmeline P Philadelphia
GUTIERREZ, MD, Felix Dauphin
GUTIERREZ, MD, Lina C Montgomery
GUTKNECHT, MD, David R Montour
GUTKOWSKI, MD, S Leonard Washington
GUTTERMAN, MD, Paul Luzerne
GUTTMAN, MD, Michael Bucks
GUTTMANN, MD, Gad G Philadelphia
GUYER, MD, Samuel Montgomery
GUZEK, MD, John R Lackawanna
GUZEK, MD, Joseph T Lackawanna
GUZMAN, MD, Jose G Northampton
GUZZARDI, MD, Lawrence J York
GUZZO, MD, Joseph C Lehigh
GVOZDEN, MD, Robert Cambria
GYDA, Michael A Students

H

HAAS, MD, Charles M Blair
HAAS, MD, Donald D Westmoreland
HAAS, MD, Janet F Philadelphia
HAAS, DO, Myron D Schuylkill
HAASE, MD, Gunter R Philadelphia
HAAZ, MD, William S Philadelphia
HABBOUSHE, MD, Fawzi P Philadelphia
HABECKER, MD, Elizabeth T Lebanon
HABER, MD, Arthur S Luzerne
HABER, MD, Richard E Allegheny
HACKMAN, MD, Vicki L Lancaster
HADDAD, MD, George R Beaver
HADDAD, MD, Robert M Montour
HADDEN, MD, Samuel B Philadelphia
HADDON JR, MD, Harry H Franklin
HADFIELD JR, MD, William A Delaware
HADLEY, MD, Carolyn B Philadelphia
HADLEY, MD, Matthew R Allegheny
HADRA, MD, Ellinor S Montgomery
HADUCK, MD, Leonard A Blair
HAEBERLE, MD, William A Philadelphia
HAECKLER, MD, William S Bucks
HAEGELE, MD, Linda A Philadelphia
HAEUSSNER, MD, Charles F Allegheny
HAFEEZ, MD, Mohammad Allegheny
HAFF, MD, Donald W Lehigh
HAFT, MD, Harold Philadelphia
HAGAMEN, MD, Mary B Crawford
HAGAN, MD, Eugene M Allegheny
HAGAN JR, MD, Eugene P Philadelphia
HAGARTY, MD, John J Montgomery
HAGERTY, MD, Fred D York
HAGES, MD, Foster Beaver
HAGG, MD, Sigrid A Allegheny
HAGGERTY, MD, Robert W Delaware
HAGGERTY, MD, Sally M Northampton
HAGSTROM, MD, Ruth M Philadelphia
HAHN, MD, Adam W Allegheny
HAHN, MD, George A Philadelphia
HAHN, MD, Jeannine R Montgomery
HAHN, MD, Jonathan F Union
HAHN, MD, Kon S Lackawanna
HAHN, MD, Richard M Washington
HAIBACH, MD, Raymond A Erie
HAIKEN, MD, Sharon S Philadelphia
HAIMOWITZ, MD, Daniel Philadelphia
HAIMOWITZ, MD, Samuel I Philadelphia
HAIN, MD, Howard L Northampton
HAIRSTON JR, MD, John C Allegheny
HAJI-DJAFARI, MD, Azizeh Venango
HAKALA, MD, Thomas R Allegheny
HAKAS, MD, Joseph F Allegheny
HAKAS JR, Joseph F Allegheny
HAKE, MD, Jean H Dauphin
HAKKARINEN, MD, William D Luzerne
HAKKI, MD, Hadi I Philadelphia
HALBERT, MD, David R Dauphin
HALE, MD, Edward H Allegheny
HALE, J Eric Students
HALE, MD, Robert G Montgomery
HALE, MD, Robert H Bucks
HALE, MD, Thomas K Schuylkill
HALE JR, MD, Raymond M Adams
HALEN, MD, Robert J Allegheny
HALENDA, MD, Gregory Dauphin
HALL, MD, Clifton R Philadelphia
HALL, MD, Daniel A Philadelphia
HALL, MD, I Macdonald Montgomery
HALL, MD, Jack R Crawford
HALL, MD, John H Philadelphia
HALL, MD, Robert L Centre
HALL, MD, Robert L Delaware
HALL, MD, Vincent B Allegheny
HALL, MD, Virginia E Dauphin
HALL, MD, Walter A Allegheny
HALL, MD, William A Allegheny
HALL II, MD, Robert F Cumberland
HALL JR, MD, John H Washington
HALLAHAN, MD, William F Lebanon
HALLE, MD, Carlton I York
HALLERMEIER JR, MD, Robert G Delaware
HALLETT, MD, Joseph W Philadelphia
HALLISEY, MD, John G Beaver
HALLMON JR, William N Allegheny
HALLOCK, MD, Geoffrey Lehigh
HALLOCK, MD, Margaret E Dauphin
HALLOCK, MD, Richard H Dauphin
HALPERIN, MD, Meyer A Monroe
HALPERN, MD, Barry R Philadelphia
HALPERN, MD, Barton L Lancaster
HALPERN, MD, Janis S Philadelphia
HALPERN, MD, Marcia L Philadelphia
HALTRECHT, DO, Leonard Delaware
HAM, MD, James W Venango
HAM, MD, Tong H Mercer
HAMADANI, MD, Houshang G Lehigh
HAMANN, MD, Jose G Philadelphia
HAMATY, MD, Ronald M Cambria
HAMBURG, MD, Allen E Montgomery
HAMIDI, MD, Jafar A Mckean
HAMILTON, MD, Angie S Philadelphia
HAMILTON, MD, Geraldine E Delaware
HAMILTON, MD, Ralph W Philadelphia
HAMILTON, MD, Robert W Dauphin
HAMILTON, Sarah L Allegheny
HAMILTON, MD, Wade T Montour
HAMILTON, MD, William C Philadelphia
HAMILTON, MD, William L Philadelphia
HAMM, MD, Charles R Allegheny
HAMM, MD, William G Lycoming
HAMMAN, MD, J Shue Dauphin
HAMME, MD, Elmer G York
HAMMETT, MD, James H Adams
HAMMETT, DO, James N Adams
HAMMOND, MD, Charles P Lancaster
HAMMOND III, MD, N Leroy Montgomery
HAMOY, MD, Alice G Lycoming
HAMOY, MD, George L Lycoming
HAMPEL, MD, Avraham Philadelphia
HAMPSEY, MD, John A Northampton
HAMPTON, MD, Janet A Philadelphia
HAMPTON, MD, Louis J York
HAMSHER, MD, Carl D Montgomery
HAMSHER, MD, James R Dauphin
HAMZAVI, MD, Siamak Lackawanna
HAN, MD, Dalsoo Allegheny
HAN, MD, Samuel I Butler
HAN, MD, Sum K Allegheny
HAN, MD, Sun Tak Lackawanna
HAN, MD, Yoong O Allegheny
HANACHE, MD, Jeanne A Chester
HANBY JR, MD, W Forwood E Montgomery
HANCOCK, MD, Reginald A Allegheny
HAND, MD, Harold R Adams
HAND, MD, John G Philadelphia
HAND, MD, Roy H Montgomery
HANDELSMAN, MD, Oliver Allegheny
HANDFORD, MD, H Allen Dauphin

HANDLER, MD, Steven D	Philadelphia
HANES, MD, Kenneth F	Westmoreland
HANES, MD, Robert B	Delaware
HANGEN, MD, Norman M	Berks
HANHAUSEN JR, MD, Edward H	Montgomery
HANISEK, MD, William F	Northampton
HANJANI, MD, Parviz	Philadelphia
HANJURA, MD, Girdhari L	Berks
HANKEY, MD, John C	Allegheny
HANLEY JR, MD, Edward N	Allegheny
HANLON, MD, James T	Allegheny
HANLON, MD, Paul A	Luzerne
HANLON, Thomas W	Allegheny
HANMER, MD, Clark B	Venango
HANNA, MD, Dwight C	Allegheny
HANNA, MD, Ezzat A	Berks
HANNA, MD, Herbert L	Indiana
HANNA, MD, Raouf E	Lackawanna
HANNA, MD, Salah G	Westmoreland
HANNUM, MD, Christopher F	Philadelphia
HANRAHAN, MD, James B	Allegheny
HANSEN, MD, Carl A	Bucks
HANSON, MD, Elbert L	Erie
HANSON, MD, Teresa S	Chester
HANSON JR, MD, C William	Philadelphia
HANSPAL, MD, Navjot S	Chester
HANZEL, MD, George D	Cambria
HAPPEL, MD, John L	Allegheny
HARADA, MD, William A	Northampton
HARADIN, MD, Anthony R	Allegheny
HARASYM, MD, Eugene D	Lackawanna
HARASYM JR, MD, E Lawrence	Columbia
HARBACH, MD, Harrison F	Adams
HARBERGER, MD, James H	York
HARBOUR, MD, Robert C	Luzerne
HARDEE, MD, Kay Cuthbert	Montgomery
HARDESTY, MD, James L	Philadelphia
HARDESTY, MD, Robert L	Allegheny
HARDING, MD, Robert L	Dauphin
HARDY, MD, Charles A	Bucks
HARDY, MD, Heidrun D	Erie
HARDY-FLUELLEN, MD, Judith M	Philadelphia
HARE, MD, Jeffrey D	Northampton
HARETOS, MD, John T	Allegheny
HARGLEROAD II, MD, John A	Centre
HARGRAVE, MD, Hugh J	Lancaster
HARGROVE III, MD, Walter C	Philadelphia
HARKCOM, MD, Richard K	Washington
HARKER EXEC, SEC, Ms Marjorie E	Blair
HARKINS, MD, Francis A	Chester
HARKINS, MD, Herbert P	Philadelphia
HARLAN, MD, William K	Northampton
HARLEY, MD, Barbara M	Cambria
HARLEY, MD, John B	Cambria
HARLEY, MD, Robison D	Philadelphia
HARLIN, MD, Joyce A	Bucks
HARM JR, MD, Kenneth R	Dauphin
HARMAN, MD, Robert G	Lehigh
HARMANCI, MD, M Cem	Mifflin/Juniata
HARMON, MD, Eli B	Montgomery
HARMON, MD, Robert L	Philadelphia
HARMON, MD, Sandra R	Montgomery
HARMON, Thomas V	Allegheny
HARNED, E Michael	Students
HARNISH, MD, David M	Lancaster
HAROSTOCK, MD, Michael D	Montour
HARP, MD, James R	Philadelphia
HARPER, MD, James G	Northampton
HARPER, MD, John B	Montgomery
HARPER, MD, Nancy L	Philadelphia
HARPS, MD, James A	Monroe
HARRER, MD, Daniel C	Delaware
HARRER JR, MD, William J	Mercer
HARRIGER, MD, Clyde E	Cambria
HARRIGER, MD, Miles D	Lancaster
HARRING, MD, Maynard	Schuylkill
HARRINGTON, MD, Thomas M	Montour
HARRIS, MD, Barry C	Allegheny
HARRIS, MD, David T	Philadelphia
HARRIS, MD, Floyd L	York
HARRIS, MD, Harold J	Luzerne
HARRIS, MD, Howard Y	Luzerne
HARRIS, MD, James S	Philadelphia
HARRIS, MD, Joseph L	Philadelphia
HARRIS, MD, Katherine K	Philadelphia
HARRIS, MD, Lawrence K	Berks
HARRIS, MD, Max	Delaware
HARRIS, MD, Richard H	Montgomery
HARRIS, MD, Richard N	Allegheny
HARRIS, MD, Ronald D	Montour
HARRIS, MD, Ronald I	Luzerne
HARRIS, MD, Stanley R	Lehigh
HARRISON, MD, Anthony M	Allegheny
HARRISON, MD, C Scott	Dauphin
HARRISON, MD, Cynthia	Lancaster
HARRISON, MD, Frank D	Westmoreland
HARRISON, MD, James L	Lycoming
HARRISON, MD, Timothy S	Lebanon
HARRISON JR, MD, Joseph	Montgomery
HARROP, MD, Donald E	Chester
HARRY, MD, Harriet M	Centre
HARSHAW JR, MD, Edward	Delaware
HARSHMAN, MD, Leroy D	Greene
HARSHMAN, MD, Mark W	Chester
HART, MD, George R	Lawrence
HART, MD, Gerard T	Philadelphia
HART, MD, James C	Dauphin
HART, MD, Neil J	Allegheny
HART, MD, Philip L	Fayette
HART, DO, William J	Delaware
HARTFORD, MD, Charles E	Delaware
HARTLE, MD, John E	Bedford
HARTMAN, MD, Charles E	York
HARTMAN, MD, Craig W	Blair
HARTMAN, MD, H King	Westmoreland
HARTMAN, MD, Michael J	Venango
HARTMAN, MD, Owen W	Franklin
HARTMAN, MD, Roderic J	Allegheny
HARTMAN, MD, William F	Lancaster
HARTMAN II, MD, Samuel A	Lebanon
HARTMANN, MD, David B	Allegheny
HARTSHORN, MD, Mary A	Philadelphia
HARTSOCK, MD, Robert J	Allegheny
HARTZ, MD, Leo M	Lycoming
HARTZELL, MD, David L	Cumberland
HARTZELL, MD, Dwight J	Philadelphia
HARTZELL JR, MD, George W	Lehigh
HARVEY, MD, Edith E	Philadelphia
HARVEY, MD, Harold A	Dauphin
HARVEY, MD, James S	Centre
HARVEY, MD, Kenneth L	Lehigh
HARVEY, MD, William D	Centre
HARVEY, MD, William J	Allegheny
HARWICK, MD, Robert D	Philadelphia
HASABNIS, MD, Suhas P	Blair
HASBACH, MD, Thomas J	Allegheny
HASBUN, MD, Franklyn A	Philadelphia
HASELHUHN, MD, Donald H	Dauphin
HASER, MD, Heywood A	Allegheny
HASHMI, MD, Majid A	Allegheny
HASIUK, MD, Aaron S	Bucks
HASKIN, MD, Marvin E	Philadelphia
HASKIN, MD, Myra R	Montgomery
HASLEY, Peggy B	Allegheny
HASSAN, MD, Joseph R	Berks
HASSEL, MD, Jeffrey L	Berks
HASSEL, MD, Patricia A	Berks
HASSEL JR, MD, Carl W	Lancaster
HASSELBACHER, MD, Frank X	Dauphin
HASSEN, MD, Irfan W	Blair
HASSOURI, MD, Hassan	Allegheny
HASTINGS JR, MD, Leo J	Lehigh
HASZ, MD, Richard D	Dauphin
HATALA, MD, John V	York
HATCHER, MD, Kim A	Indiana
HATCHER, MD, Ronald A	Dauphin
HATFIELD, MD, Charles R	Dauphin
HATLEY, MD, Walter F	Philadelphia
HATTI, MD, Shivkumar S	Delaware
HATTON, MD, Duncan S	Delaware
HATTOUM, MD, Pittagore	Westmoreland
HAUCH, MD, James F	Warren
HAUCK, MD, Randy M	Dauphin
HAUCK, MD, Samuel M	Lancaster
HAUER, MD, Marlin L	Lebanon
HAUGER, MD, Harold N	Westmoreland
HAUGER, MD, William D	Cambria
HAUK, MD, William L	Allegheny
HAUPT, MD, George J	Philadelphia
HAUS, MD, William	Allegheny
HAUSER, MD, John R	Washington
HAUSER, MD, Norman	Montgomery
HAUSER, MD, Raymond J	Berks
HAUT, MD, Michael J	Philadelphia
HAVENS JR, MD, Walter P	Philadelphia
HAVER, MD, Paul M	Beaver
HAVKO, Frederick C	Allegheny
HAWK, MD, Brainard O	Allegheny
HAWK, MD, David L	York
HAWKINS, MD, Edward R	Bucks
HAWKINS, MD, James G	Allegheny
HAWKINS, MD, Walter D	Dauphin
HAWLEY, MD, Richard C	Schuylkill
HAWN, MD, Margaret M	Dauphin
HAWRYLUK, Joseph M	Allegheny
HAY, MD, Harold S	Somerset
HAYASHI, MD, T Terry	Allegheny
HAYAT, MD, Shaukat	Westmoreland
HAYES, MD, Brian L	Philadelphia
HAYES, MD, George T	Philadelphia
HAYES, MD, James C	Allegheny
HAYES, MD, James D	Allegheny
HAYES, MD, Merrill B	Delaware
HAYES, Timothy J	Students
HAYES, MD, Warren H	Lycoming
HAYES JR, MD, Martin F	Philadelphia
HAYESLIP, MD, David W	Allegheny
HAYFORD JR, MD, Hugh	Blair
HAYLLAR, MD, Benjamin L	Philadelphia
HAYMAN, MD, Harris R	Chester
HAYMAN, MD, Harry B	Bucks
HAYNICZ, MD, Peter	Monroe
HAYS, MD, E Blaine	Cumberland
HAYTHORNTHWAITE, MD, B Mary	Montgomery
HAYWARD, MD, Richard B	Montgomery
HAZLETT, MD, Jane	Luzerne
HAZLETT, MD, William H	Luzerne
HAZLETT JR, MD, Walter S	Westmoreland
HAZZOURI, MD, Michele A	Lackawanna
HEADLEY, MD, Chauncey R	Washington
HEANEY, MD, Steven J	Bradford
HEAPS, MD, Kenneth P	York
HEARTER JR, MD, William R	Lycoming
HEASLEY, MD, Kenneth H	Venango
HEATH, MD, Erle M	Allegheny
HEATH, MD, Robert D	Montour
HEATON, MD, Vincent W	Blair
HEAZLETT, MD, William A	Allegheny
HEBERLING, MD, Thomas P	Lebanon
HECHT, MD, Paul J	Philadelphia
HECHT, MD, Warren B	Montgomery
HECK, MD, Christopher C	Westmoreland
HECK, MD, Harry J	Allegheny
HECK III, MD, Harry J	Allegheny
HECKLER, MD, Frederick R	Allegheny
HECKLIN, MD, Oscar B	Philadelphia
HEDGES JR, MD, Thomas R	Philadelphia
HEDRICK, MD, Gerald W	Bucks
HEDRICK, MD, Thomas A	Cambria
HEERE, MD, Barbara A	Lycoming
HEFFERN, MD, James E	Lancaster
HEFFERNAN, MD, Andrew H	Lehigh
HEFFERNAN, MD, John M	Berks
HEFFLEY, MD, William M	Dauphin
HEFFLIN, MD, Charles M	Allegheny
HEGARTY, MD, Francis A	Allegheny
HEIBEL, MD, Richard H	Erie
HEID, MD, Charles E	Montour
HEIDARY, MD, Ghodratallah	Montgomery
HEIDENREICH, MD, Fred P	Allegheny
HEIDENREICH, MD, H Vincent	Allegheny
HEILIGMAN, MD, Nathan H	Lehigh
HEILMAN, MD, Howard C	Armstrong
HEILMAN, MD, J Daniel	Allegheny
HEILMANN, MD, Timothy M	Allegheny
HEIM, MD, William J	Lackawanna
HEIMAN, MD, Donald F	Philadelphia
HEIMBACH, MD, George Z	Northampton
HEIMBACH, MD, James A	Blair
HEINBACH, MD, Robert A	Northumberland
HEINBACH, MD, Wilfred F	Berks
HEINBACH JR, MD, Robert A	Lycoming
HEINE, MD, William I	Philadelphia
HEINLE JR, MD, Edward W	Beaver
HEINLE JR, MD, Frederick J	Lancaster
HEIRD, MD, Steven B	York
HEISE, MD, Glen E	Dauphin
HEISEY, MD, John C	Berks
HEISEY, MD, Robert G	Lebanon
HEISTAND, MD, Landis C	Schuylkill
HEISTER, MD, Joseph B	Westmoreland
HEISTERKAMP III, MD, Charles A	Lancaster
HELFER, MD, Elizabeth L	Philadelphia
HELFFRICH, MD, Richard S	Blair
HELFMAN, Laura L	Students
HELFRICH, MD, David J	Allegheny
HELFRICK, MD, Marlin W	Mifflin/Juniata
HELLER, MD, Alvin G	Philadelphia
HELLER, MD, Fredericka S M	Berks
HELLER, MD, Harry E	Delaware
HELLER, MD, John E	Allegheny
HELLER, MD, Melvin S	Philadelphia
HELLER, MD, Robert S	Philadelphia
HELLERMAN, MD, Pamela E	Montour
HELM, MD, Robert C	Lancaster
HELM JR, MD, John D	Lancaster
HELMBOLD, MD, Theodore R	Allegheny
HELMICK, MD, Nathaniel D	Monroe
HELMICK, MD, Wayne W	Beaver
HELRICH, MD, Martin	Philadelphia
HELSING, MD, Walter J	Beaver
HELWIG JR, MD, John	Philadelphia
HELY, MD, Daniel P	Cumberland
HELZNER, MD, Eileen C	Bucks
HELZNER, MD, Richard C	Bucks
HEMLER, MD, Paul M	Dauphin
HEMMERLY, MD, William C	Northampton
HEMPHILL, MD, Richard W	Allegheny
HENDERSON, MD, Ellsworth W	Erie
HENDERSON, MD, K Wayne	Lycoming
HENDERSON, MD, Peter B	Allegheny
HENDERSON, MD, Robert E	Lawrence
HENDERSON, MD, Rugh A	Dauphin
HENDERSON, MD, Theodore A	Montgomery
HENDERSON, MD, William H	Delaware
HENDLER, MD, Barry H	Philadelphia
HENDLER, MD, Howard M	York
HENDLER, MD, Steven L	Philadelphia
HENDRICKS, MD, Robert T	Crawford
HENDRICKS JR, MD, Gilbert L	Centre
HENDRICKS JR, MD, William C	Erie
HENDRICKSON, MD, Donald C	Franklin
HENDRICKSON, MD, Frank O	Delaware
HENDRIX, MD, Robert A	Philadelphia
HENDRY, MD, Stanley G	Allegheny
HENNESSY, DO, Michael P	Philadelphia
HENNIGAN, MD, John J	Lackawanna
HENNING III, MD, George F	Susquehanna
HENNINGER, MD, James M	Allegheny
HENNINGER, MD, William H	Berks
HENNON, MD, Don L	Allegheny
HENRIQUES, MD, Errol D	Cambria
HENRIQUEZ, MD, Jack A	Lehigh
HENRY, MD, Leland T	Armstrong
HENRY, MD, Nelson K	Philadelphia
HENRY, MD, Stephen J	Delaware
HENRY, MD, Walter J	Mckean
HENRY JR, MD, Edgar S	Allegheny
HENRY JR, MD, Leland T	Allegheny
HENSLEY, MD, Frederick A	Dauphin
HENTOSH, MD, John P	Lehigh
HEPLER, MD, Kevin M	Chester
HEPP, MD, Joseph A	Allegheny
HEPPNER, MD, Richard L	Allegheny
HERB, MD, Robert W	Allegheny
HERBERT, DO, Rex A	Dauphin
HERBERT, MD, Vicki L	Allegheny
HERBISON, MD, Gerald J	Philadelphia
HERBST, MD, Bernadette A	Philadelphia
HERCEG, MD, Stephen J	Dauphin
HERGENROEDER, MD, Paul F	Philadelphia
HERGESHEIMER, MD, Lester	Philadelphia
HERLING, MD, Patti J	Philadelphia
HERMAN, MD, Carl D	Philadelphia
HERMAN, MD, Dennis	Philadelphia
HERMAN, Gregory E	Students
HERMAN, MD, Harold	Philadelphia
HERMAN, MD, Jay B	Allegheny
HERMAN, MD, Jerry H	Philadelphia
HERMAN, MD, Julius	Allegheny
HERMAN, MD, Marianne	Philadelphia
HERMAN, MD, Richard D	Northampton
HERMAN, MD, Roman K	Northampton
HERMAN, MD, Ronald J	York
HERMAN, MD, Walter M	Philadelphia
HERMANN, MD, Christopher P	Bucks
HERMANN, MD, George A	Philadelphia
HERMANOVICH JR, MD, John	Berks
HERMANSEN, MD, Bruce A	Allegheny
HERNANDEZ, MD, Pedro A	Allegheny
HERNANDEZ, MD, Santiago J	Philadelphia
HERNANDEZ, MD, Wilbert E	Luzerne
HEROLD, MD, Sanford L	Philadelphia
HEROLD JR, MD, Creston C	Dauphin
HERR, MD, Daniel L	Lancaster
HERRERA, MD, Anibal F	Delaware
HERRING, MD, Allen B	Philadelphia
HERRING, MD, Christina S	Philadelphia
HERRING, MD, Lynn B	Bucks
HERRING, Steven J	Students
HERRING, MD, William	Philadelphia
HERRMANN, MD, William J	Luzerne
HERROLD, MD, Lewis C	York
HERROLD, MD, Warren C	York
HERRON, MD, Eugene W	Westmoreland
HERSCHAFT, MD, Richard J	Lancaster
HERSCHMANN, MD, Katharine	Philadelphia
HERSHENSON, MD, Lee M	Allegheny
HERSHEY, MD, Richard E	Allegheny
HERSHFIELD, MD, David H	Lackawanna
HERSHOCK, MD, Bruce A	Westmoreland
HERSPERGER, MD, Webb S	Cumberland
HERTZ, MD, Barry C	Chester
HERTZ, MD, Charles S	Lehigh
HERTZ, MD, Jonathan	Lehigh
HERTZLER JR, MD, John V	Cumberland
HERTZOG, MD, Francis J	Allegheny
HERTZOG, MD, James E	Allegheny
HERZEL JR, MD, Frank B	Dauphin
HERZLBETZ, MD, Kenneth J	Philadelphia
HERZOG, MD, Robert S	Philadelphia
HESBACHER, MD, Edwin N	Montour
HESKEL, MD, Milton M	Philadelphia
HESS, MD, Edward R	Tioga
HESS, MD, Floyd M	Northampton
HESS, MD, Ivan W	Montgomery
HESS, MD, Joseph B	Lancaster
HESS JR, MD, Grant E	Washington
HETHERINGTON, MD, Arthur F	Allegheny
HETRICK, MD, William D	Allegheny
HETRICK JR, MD, Theodore L	Northumberland
HETZLER, MD, Norman A	Beaver
HEUERMANN, MD, Robert P	Lancaster
HEWLETT, MD, John O	Dauphin
HEWSON, MD, William C	Chester
HEY JR, MD, E Berry	Berks
HEYDT, MD, Stuart	Luzerne
HEYDT JR, MD, Ernest H	Montgomery
HEYER, MD, Bonnie L	Montgomery
HEYL, MD, Louis W	Allegheny
HEYL, MD, W Meredith	Philadelphia
HEYL JR, MD, Frank E	Allegheny
HEYMACH III, MD, George J	Allegheny
HEYMAN, MD, David Coleman	Lycoming
HIBBARD, MD, Alanson O	Crawford
HIBBS, MD, John B	Fayette
HICKEY, MD, Andrew E	York
HICKEY JR, MD, Daniel	Montgomery
HIDALGO, MD, Horacio A	Bucks
HIEHLE, MD, John F	Berks
HIEMENZ, MD, Donald W	Monroe
HIGH, MD, Bertrand J	Berks
HIGMAN, MD, Henry B	Allegheny
HIJAZI, MD, Saadeddine A	Lackawanna
HILAL, MD, Elias Y	Allegheny
HILBERG, MD, Robert W	Allegheny
HILE, MD, H Eugene	Allegheny
HILEMAN, MD, James D	Erie
HILES, MD, David A	Allegheny
HILGER, Jeffrey S	Allegheny
HILL, MD, Daniel E	Lycoming
HILL, MD, E Merton	Lehigh
HILL, MD, Edward	Cambria
HILL, MD, John B	Allegheny
HILL, MD, Michael A	Philadelphia
HILL, MD, Robert J	Blair
HILL, MD, Walter C	York
HILL, MD, William R	Jefferson
HILL JR, MD, Robert G	Northampton
HILLEMEIR, MD, Herbert	Blair
HILLER JR, MD, Walter W	Allegheny
HILLERMAN, MD, Braxton L	Luzerne
HILLIKER, MD, Jan K	Montour
HILLYER, MD, Peter N	Chester
HILTON, MD, Alexander E	Allegheny

HIMELFARB, MD, Hillard M	Franklin
HIMELFARB, MD, Paul	Allegheny
HIMES, DO, Rand S	Allegheny
HIMES JR, MD, Ralph F	Blair
HIMMELSTEIN, MD, Eugene	Delaware
HIMMELSTEIN, MD, Fred R	Berks
HIMOT, MD, Linda J	Allegheny
HINCHBERGER, MD, Paul A	Butler
HINCHLIFFE, MD, Joseph G	Allegheny
HINEMAN, MD, Marquis W	Beaver
HINES, MD, Joseph H	Erie
HINKENS, MD, George F	Allegheny
HINKLE, DO, Richard S	Montour
HINRICHS, MD, Thomas F	Berks
HINSMAN JR, MD, John A	Bradford
HINTON, MD, Drury	Delaware
HIPOLITO, MD, Aurora T	Clearfield
HIPOLITO, MD, Ernesto A	Clearfield
HIPOLITO JR, MD, Emmanuel F	Lackawanna
HIPP, MD, Thomas J	Bucks
HIPPERT, DO, Robert K	Berks
HIPPLE, MD, Randall F	Lycoming
HIPPS, MD, John G	Clarion
HIRSCH, MD, Barry E	Allegheny
HIRSCH, MD, Bernard	Beaver
HIRSCH, MD, Glenn M	Lebanon
HIRSCH, MD, Jack H	Erie
HIRSCH, MD, Stanley A	Allegheny
HIRSCH, MD, Stuart D	Allegheny
HIRSCH, MD, William P	Cambria
HIRSH, MD, Bernard C	Philadelphia
HIRSH, MD, Leonard F	Delaware
HIRSH, MD, Paul D	Berks
HIRSH, MD, Robert A	Philadelphia
HIRSH, MD, S Jay	Delaware
HIRSH, MD, Steven L	Philadelphia
HISRICH, MD, Glenn D	Washington
HITCHCOCK, MD, John	Allegheny
HITCHNER, MD, Lewis C	Delaware
HIZNAY, Karen A	Students
HLAVAC, MD, Cheryl A	Luzerne
HNELESKI JR, MD, Ignatius S	Chester
HO, MD, John J	Philadelphia
HO, MD, Monto	Allegheny
HO, MD, Raymond C	Erie
HO, MD, Szekey	Erie
HO, MD, Yee C	Allegheny
HOBART, MD, John H	Northampton
HOBBS, MD, Joseph H	Schuylkill
HOBBS, MD, Robert E	Schuylkill
HOBBS, MD, Thomas R	Dauphin
HOBERMAN, MD, Edward	Clinton
HOBERMAN, MD, Maury	Chester
HOBSON, MD, John J	Delaware
HOCH, MD, Bradley R	Adams
HOCH, MD, Carl W	Allegheny
HOCH, MD, John J	Northampton
HOCH, MD, John R	Philadelphia
HOCH, Mark L	Allegheny
HOCHBERG, MD, Robert D	Philadelphia
HOCHMAN, MD, Rodney F	Bradford
HOCHREITER, DO, George C	Lancaster
HODES, MD, Philip J	Philadelphia
HODGE, MD, Arthur J	Dauphin
HODGE, MD, Ian G	Lancaster
HODGENS, MD, Helen L	Philadelphia
HODGES, MD, John H	Philadelphia
HODGSON, MD, John P	Allegheny
HOENSTINE, MD, Arthur C	Lawrence
HOERNER, MD, George H	York
HOERNER, MD, Oscar G	Cumberland
HOERNER, MD, Ralph W	Philadelphia
HOFFER, MD, Richard S	Berks
HOFFMAN, MD, Arthur D	Lehigh
HOFFMAN, MD, Bruce I	Philadelphia
HOFFMAN, MD, Carl J	Montgomery
HOFFMAN, MD, Chauncey	Cambria
HOFFMAN, MD, David A	Berks
HOFFMAN, MD, David J	York
HOFFMAN, MD, Franklin D	Allegheny
HOFFMAN, MD, Gilbert M	Northampton
HOFFMAN, MD, Glenn H	Lebanon
HOFFMAN, MD, Howard L	Franklin
HOFFMAN, MD, J David	Philadelphia
HOFFMAN, MD, J Lynn	Cumberland
HOFFMAN, MD, James P	Montgomery
HOFFMAN, MD, John E	Northampton
HOFFMAN, DO, Marc E	Allegheny
HOFFMAN, MD, Neil A	Berks
HOFFMAN, MD, Richard R	Lebanon
HOFFMAN, MD, Richard R	York
HOFFMAN, MD, Salee L	Blair
HOFFMAN, MD, Vicki N	Philadelphia
HOFFMAN, MD, William J	Westmoreland
HOFFMAN, MD, William S	Northampton
HOFFMAN, MD, William W	Lehigh
HOFFMAN JR, MD, Donald B	Lancaster
HOFFMAN JR, MD, George L	Philadelphia
HOFFMAN JR, MD, Harry H	Lancaster
HOFFMAN JR, MD, Nicholas F	Philadelphia
HOFFMANN, MD, Ursula M	Lehigh
HOFFMASTER, MD, Alfred L	Lawrence
HOFFMEIER, MD, Charles L	Philadelphia
HOFKOSH, MD, Dena	Allegheny
HOFMAN, MD, Walter I	Montgomery
HOFMANN, MD, James W	York
HOFSTETTER, MD, Alexander M	Allegheny
HOFSTROM, MD, Glen T	Lycoming
HOGG, MD, Susan M	Lancaster
HOHING, MD, Charles C	Allegheny
HOHMAN, MD, Karl V	Washington
HOHMANN, MD, Thomas C	Allegheny
HOKE JR, MD, Hugh H	Lancaster
HOLCOMBE JR, MD, Guy T	Chester
HOLDER, MD, Arthur J	Lancaster
HOLENCIK, DO, Mark P	Dauphin
HOLFELNER, MD, Edward D	Philadelphia
HOLGADO, MD, Edgardo B	Philadelphia
HOLGADO, MD, Priscila C	Delaware
HOLL, MD, Paul F	Allegheny
HOLLA, MD, P Shripathi	Lackawanna
HOLLAND, MD, Baxter C	Philadelphia
HOLLAND, MD, Clarence A	Lehigh
HOLLAND, MD, Edward F	York
HOLLAND, MD, Mark P	Schuylkill
HOLLAND, MD, Philip B	Allegheny
HOLLAND, MD, Sanford J	Lackawanna
HOLLAND JR, MD, Clarence A	Lehigh
HOLLAND JR, MD, William T	Crawford
HOLLANDER, MD, Bentley A	Philadelphia
HOLLANDER, MD, George	Philadelphia
HOLLANDER, MD, Irwin J	Bucks
HOLLANDER, MD, Joseph L	Philadelphia
HOLLEN, MD, Robert A	Cumberland
HOLLENBAUGH, MD, Fonda	Allegheny
HOLLERAN, MD, Bernard L	Luzerne
HOLLERMAN, MD, Charles E	Allegheny
HOLM, MD, Eric K	Berks
HOLM, MD, William W	Montgomery
HOLMAN, MD, Ingrid A	Allegheny
HOLMBERG, MD, Donald E	Montgomery
HOLMES, MD, John J	Lackawanna
HOLMES, Lynette	Allegheny
HOLMES, MD, Robert B	Venango
HOLMES, MD, Thomas R	Erie
HOLMES, MD, William F	Montgomery
HOLMES, DO, William R	Delaware
HOLMS, DO, Barry C	Delaware
HOLROYDE, MD, Christopher P	Philadelphia
HOLSINGER, David F	Allegheny
HOLST, MD, Hazel I	Delaware
HOLST, MD, Robert A	Westmoreland
HOLSTEIN, MD, James J	Delaware
HOLT, MD, Allen H	Mercer
HOLTZMAN, MD, Henry B	Bucks
HOLZINGER, MD, Elmer J	Allegheny
HOLZMAN, MD, Lawrence B	Philadelphia
HOMILY, MD, Blessing B	Susquehanna
HONG, MD, Keumsoon	Philadelphia
HONG, MD, Soo W	Lycoming
HONG, MD, Sung H	Beaver
HONG, MD, Sunwha	Philadelphia
HONGBARCO, MD, Pablo	Allegheny
HONIGMAN, MD, Frederic H	Philadelphia
HONISH, MD, Robert L	Philadelphia
HOOBLER, MD, James L	Chester
HOOD, MD, Henry L	Montour
HOOKER, Maryann D	Students
HOON, MD, William L	Allegheny
HOOTMAN, MD, Barry D	Butler
HOOTMAN, MD, J Kenneth	Allegheny
HOOVER, MD, Alan D	Allegheny
HOOVER, MD, Carl H	Lancaster
HOOVER, MD, Dean S	York
HOOVER, MD, Philip A	York
HOOVER, MD, Walter W	Allegheny
HOOVER II, MD, Benjamin A	York
HOOVLER, MD, Philip W	Blair
HOPKINS, MD, Arthur J	Philadelphia
HOPKINS, MD, F Thomas	Montgomery
HOPKINS, MD, John E	Montgomery
HOPKINS, MD, Robert G	Lancaster
HOPKINSON 3RD, MD, John H	Montgomery
HOPPER, MD, Bruce D	Montgomery
HORAN, MD, Charles A	Philadelphia
HORAN, MD, Gerald W	Philadelphia
HORCHOS, MD, Donald D	Lackawanna
HORMAN, MD, Marc J	Montgomery
HORMOZDI, MD, Fraydoon	Beaver
HORN, MD, Lawrence J	Philadelphia
HORN, MD, Richard H	Allegheny
HORN, MD, William A	Montgomery
HORN III, MD, Frank W	York
HORNE, MD, Lloyd M	Allegheny
HORNER, MD, George J	Philadelphia
HORNER JR, MD, Daniel W	Montgomery
HORNER JR, MD, Frank S	Allegheny
HORNIG-ROHAN, James E	Students
HORNIG-ROHAN, Mady	Students
HOROWITZ, DO, Gary R	Philadelphia
HOROWITZ, Joel	Allegheny
HOROWITZ, MD, Leonard N	Philadelphia
HORST, MD, Elmer L	Berks
HORVAT, MD, Arthur J	Luzerne
HORVAT, MD, John F	Lehigh
HORVATH, MD, David A	Allegheny
HORVATH, MD, Ronald J	Montgomery
HORWIN, MD, Samuel	Cambria
HORWITZ, MD, Brett R	Philadelphia
HORWITZ, MD, Milton R	Bucks
HORWITZ, MD, Orville	Philadelphia
HOSFELD, MD, S Marjorie	Chester
HOSHAUER, MD, Cathy J	Berks
HOSPODAR, Mark E	Allegheny
HOSSAIN, MD, Ayesha	Westmoreland
HOST, MD, William R	Wyoming
HOSTEN, MD, Edward B	Philadelphia
HOSTETTER, MD, Abram M	Lebanon
HOTTENSTEIN, MD, Daniel W	Dauphin
HOTTENSTEIN, MD, Esther	Dauphin
HOTTENSTEIN, MD, Jonathan E	Allegheny
HOU, MD, Ching W	Erie
HOUCK JR, MD, John R	Dauphin
HOUGAARD, MD, John P	Bucks
HOUGH, MD, Rodney K	Cumberland
HOUIDES, MD, Athanasios C	Lehigh
HOULE, MD, Laurent B	Philadelphia
HOULIHAN, MD, Carl T	Delaware
HOUSE, MD, Benjamin	Philadelphia
HOUSEL, MD, Edmund L	Philadelphia
HOUSER, MD, Benjamin P	Carbon
HOUSER, MD, James J	Venango
HOUSMAN, MD, John H	Lancaster
HOUSTON, MD, James L	Westmoreland
HOUSTON, MD, John B	Montour
HOUSTON, MD, R Ross	Lawrence
HOUSTON JR, MD, Robert R	Lawrence
HOWALT, MD, Kristopher D	Philadelphia
HOWANITZ, MD, Emil P	Luzerne
HOWANITZ, MD, Michael P	Dauphin
HOWARD, MD, Lawrence J	Lackawanna
HOWARD, MD, Thomas K	York
HOWE, MD, Francis R C	Dauphin
HOWE, MD, J Dale	Northampton
HOWELL, MD, John T	Bucks
HOWELL, Thomas M	Students
HOWER, MD, Robert D	Allegheny
HOYER, MD, Paul J	Philadelphia
HOYLE, MD, J Preston	Union
HOYSON, MD, Gregory M	Allegheny
HOYT, MD, Ralph C	Berks
HRINDA, MD, John G	Erie
HRYSHKO, MD, Frank G	Allegheny
HSIEH, MD, Yehchiu	Delaware
HSU, MD, Shien S	Washington
HU, MD, Benjamin V	Allegheny
HU, MD, Kang-Ning	Allegheny
HU, MD, Wei-Tzer	Schuylkill
HUANG, MD, Chau Fe	Lackawanna
HUANG, Julian C	Allegheny
HUBBARD, MD, Charles C	Fayette
HUBBARD, MD, John P	Philadelphia
HUBER, MD, David S	Allegheny
HUBER, MD, Donald J	Allegheny
HUBER, MD, Richard L	Lackawanna
HUBER, MD, William B	Allegheny
HUDAK, MD, Mary J	Delaware
HUDIS, MD, Clifford A	Philadelphia
HUDOCK JR, MD, George E	Luzerne
HUDSON, MD, Clifford C	York
HUDSON, MD, Howard L	Erie
HUDSON JR, MD, Howard E	Lehigh
HUDZINSKI, MD, Lori D	Beaver
HUDZINSKI, MD, Martin	Franklin
HUEN, MD, Lai-Har L	Philadelphia
HUFFER, MD, Donald H	York
HUFFMAN, MD, Charles R	Greene
HUFFNAGLE, MD, Henry W	Lancaster
HUGHES, MD, Boland	Philadelphia
HUGHES, MD, Christopher M	Allegheny
HUGHES, MD, David C	Indiana
HUGHES, MD, David P	Lancaster
HUGHES, MD, Eugene P	Philadelphia
HUGHES, MD, George V	Allegheny
HUGHES, MD, Howard G	Montour
HUGHES, MD, Joseph P	Washington
HUGHES, MD, Patrick H	Allegheny
HUGHES, MD, Paul J	Luzerne
HUGHES, MD, William M	Westmoreland
HUGHES JR, MD, Eugene P	Philadelphia
HUGHEY, MD, James R	Washington
HUGO, Maryanne	Allegheny
HUHN, MD, Wolfgang A	Bucks
HULIHAN JR, Joseph F	Students
HULL, MD, Ben L	Blair
HULLEY JR, MD, William C	Allegheny
HULNICK, MD, Stuart J	Philadelphia
HUME, MD, Eric L	Philadelphia
HUME, MD, John M	Dauphin
HUMES, MD, Alexander B	Allegheny
HUMMER JR, MD, Charles D	Delaware
HUMPHREYS, MD, Earl A	Allegheny
HUMPRIES, MD, Thomas J	Philadelphia
HUNDLEY, MD, J Warren	Philadelphia
HUNSBERGER, MD, Charles L	Cambria
HUNSBERGER, MD, Joseph L	Montgomery
HUNSICKER, MD, Llewellyn W	Monroe
HUNSICKER, MD, Robert C	Northampton
HUNT, MD, Eugene H	Bucks
HUNT, MD, Jeffrey I	Philadelphia
HUNT, MD, Josiah A	York
HUNT, MD, Robert E	Butler
HUNT, MD, William D L	Lancaster
HUNT, MD, William R	Allegheny
HUNT JR, MD, Wm T	Philadelphia
HUNTER, MD, Carol A	Tioga
HUNTER, MD, Doris M	Allegheny
HUNTER, MD, Frances C	Philadelphia
HUNTER, MD, George R	Westmoreland
HUNTER, MD, James M	Philadelphia
HUNTER, MD, John S	Berks
HUNTER, MD, Marvin T	Bucks
HUNTER, MD, Robert G	Columbia
HUNTER, MD, Robert J	Centre
HUNTLEY, MD, Arthur C	Montgomery
HUOT, MD, David A	Allegheny
HUPPERT, MD, Leonore C	Philadelphia
HUR, MD, Gham	Chester
HUREWITZ, MD, Sylvan J	Philadelphia
HURITE, MD, Francis G	Allegheny
HURLEY, MD, Harry J	Delaware
HURLEY, MD, John N	Philadelphia
HURLOCK, MD, Joan E	Philadelphia
HURST, MD, John W	Blair
HURST, MD, Kenneth L	Lycoming
HURWITZ, MD, Abraham	Philadelphia
HURWITZ, DO, Charles	Philadelphia
HURWITZ, MD, Dennis J	Allegheny
HURWITZ, MD, Larry E	Allegheny
HUSAIN, MD, Akhter F	Erie
HUSAIN, MD, Zahid	Luzerne
HUSAINI, MD, Syed N	Allegheny
HUSHION, MD, William F	Delaware
HUSSAINI, MD, Syed R	Allegheny
HUST, MD, Frederick S	Butler
HUSTON, MD, Charles C	Clarion
HUTCHINGS, MD, Diana M	Bucks
HUTCHINS, MD, Kim L	Philadelphia
HUTCHINSON, MD, Thomas A	Lehigh
HUTCHINSON, William S	Allegheny
HUTCHINSON 3D, DO, Harry J	Chester
HUTCHISON, MD, James C	Montgomery
HUTCHISON, MD, William A	Lancaster
HUTH, MD, Edward J	Philadelphia
HUTTON, MD, John E	York
HUWE JR, Joseph E	Allegheny
HUXSTER, MD, Robert H	Chester
HWAN, MD, Jung J	Lackawanna
HYATT, MD, Floyd R	Erie
HYATT, MD, Glenn A	Montgomery
HYATT, MD, Robert W	Philadelphia
HYDE-ROWAN, MD, M Deborah	Bradford
HYDOVITZ, MD, Jerrold D	Allegheny
HYETT, MD, Marvin R	Philadelphia
HYKES, MD, James I	Montgomery
HYLBERT JR, MD, Kenneth Wm	Centre
HYLEK, Elaine M	Allegheny
HYLTON, MD, Casimer	Philadelphia
HYMAN, MD, David S	Northampton
HYMAN, MD, Harold L	Philadelphia
HYMAN, MD, Herbert L	Lehigh
HYNES, MD, John J	Philadelphia
HYZINSKI, MD, Martin B	Philadelphia

I

IAMS, MD, William B	Dauphin
IANCU, MD, Albert L	Allegheny
IANNUZZI, MD, C Charles	Allegheny
IBANEZ, MD, Melchisedec	Mckean
IBARS, MD, George C	Philadelphia
ICHTER, MD, Jon R	Lancaster
ICHTER, MD, Joseph T	Dauphin
ICLI, MD, Nadir	Westmoreland
IDDENDEN, MD, David A	Philadelphia
IDICULLA, MD, Anne A	Philadelphia
IDREES, MD, Muhammad	Allegheny
IDUCOVICH, MD, Nicholas	Westmoreland
IGLESIAS, MD, Manuel	Lancaster
IGNACIO, Kathlyn R	Students
IGNACIO JR, MD, Glicerio V	Cambria
IGNATIUS, MD, Paul F	Warren
ILIOFF, MD, Gregory L	Lehigh
ILKHANIPOUR, MD, Cyrus	Allegheny
ILLINGWORTH, DO, William A	Bedford
ILYAS, MD, Mohammad	Allegheny
IMAIZUMI, MD, Shotaro	Delaware
IMBER, MD, Irving	Berks
IMBRIE, MD, David E	Butler
IMBRIGLIA, MD, Joseph E	Luzerne
IMBRIGLIA JR, MD, Joseph E	Allegheny
IMPERATO, MD, Pascal J	Chester
IMPERIALE, MD, Salvatore M	Luzerne
IMPINK, MD, Robert R	Berks
INDORATO, MD, Leroy S	Allegheny
INGAGLIO, MD, Philip E	Philadelphia
INGERSOLL, MD, Charles J	Philadelphia
INGRAM, MD, David N	Washington
INNERS, MD, Charles R	Dauphin
INNIS, MD, Patricia A	Berks
INOUYE, MD, William Y	Philadelphia
INSLEY JR, MD, Marion C	Dauphin
INTRIERI, Peter M	Allegheny
IOZZI, MD, Louis	Delaware
IRANI, MD, Roshen N	Philadelphia
IRBY, MD, Susan K	Allegheny
IREY JR, MD, Philip M	Columbia
IRWIN, MD, David H	Dauphin
ISAACS, MD, Charles T	Dauphin
ISAACS, MD, Gilbert H	Allegheny
ISAACSON, MD, Howard	Philadelphia
ISAACSON, MD, Stanford	Allegheny
ISAKOV, MD, Asparuh D	Lackawanna
ISARD, MD, Harold J	Philadelphia
ISARIYAWONGSE, MD, Prakorb	Fayette
ISDANER, MD, Neil L	Philadelphia
ISENBERG, MD, Chester L	Huntingdon
ISENBERG, MD, Richard A	Philadelphia
ISHLER, MD, H Richard	Centre
ISIDRO, MD, Eugenio G	Lawrence
ISLAMOFF, MD, Igor I	Cambria
ISMAIL-BEIGI, MD, Farhad	Allegheny
ISRAEL, MD, Harold L	Philadelphia
ISRAEL, MD, Michael	Allegheny
ISRAEL, MD, Robert H	Warren
ITKIN, MD, Irving H	Philadelphia
ITSKOWITZ, MD, Alan L	Allegheny
IVANOFF, MD, John G	Philadelphia

IVINS, MD, J Leonard	Delaware
IVINS, MD, Joseph L	Delaware
IVINS, MD, Samuel P	Delaware
IVINS, MD, Seth L	Delaware
IVKER, MD, Milton	Philadelphia
IVKER, MD, Morris	Montgomery
IZANT, MD, Timothy H	Philadelphia
IZZO, MD, Kenneth L	Philadelphia

J

JABLON, MD, Norman C	Montgomery
JABLONSKI, MD, Richard R	Allegheny
JABLONSKY, MD, Albert	Westmoreland
JABRI, MD, Sabah E	Armstrong
JACEY, MD, Sigmund M	Schuylkill
JACKLINE JR, MD, Joseph J	Allegheny
JACKSON, Althea J	Students
JACKSON, MD, Christann L	Allegheny
JACKSON, MD, Frank W	Dauphin
JACKSON, MD, George L	Dauphin
JACKSON, MD, Jay R	York
JACKSON, MD, Mark A	Lancaster
JACKSON, MD, Melvin L	Philadelphia
JACKSON, MD, Merwin R	Chester
JACKSON, MD, Paul W	Delaware
JACKSON, MD, T Scott	Berks
JACOB, MD, Joseph P	Philadelphia
JACOB, MD, W Lindsay	Allegheny
JACOB JR, MD, Herbert E	Allegheny
JACOBELLI, MD, Michael C	Bucks
JACOBIUS, MD, Henry F	Northampton
JACOBS, MD, Clyde H	Northumberland
JACOBS, MD, David	Allegheny
JACOBS, MD, Francis	Chester
JACOBS, MD, George A J	Allegheny
JACOBS, MD, Irvin	Luzerne
JACOBS, MD, John B	Montgomery
JACOBS, MD, Joseph A	Philadelphia
JACOBS, MD, Kenneth M	Lackawanna
JACOBS, MD, Mark	Delaware
JACOBS, MD, Martin	Mckean
JACOBS, MD, Robert P	Philadelphia
JACOBS, MD, Robert V	Somerset
JACOBS, MD, Samuel A	Allegheny
JACOBS, MD, Stanley R	Philadelphia
JACOBSON, MD, Horace H	Bradford
JACOBSON, MD, Louise	Lackawanna
JACOBSON, MD, Martin A	Berks
JACOBSTEIN, MD, Jerome G	Philadelphia
JACOBUCCI, MD, Nicola J	Beaver
JACOBUS, MD, Paula A	York
JACOBY, MD, Jay	Philadelphia
JACOBY, MD, Richard A	Philadelphia
JACQUES, MD, Charles H	Lycoming
JACQUES, MD, George A	Allegheny
JAECKLEIN, MD, Frederick P	Erie
JAEGER, MD, Edward A	Delaware
JAEGER, MD, Robert M	Lehigh
JAEGER, MD, Scott H	Philadelphia
JAFAR, MD, Mohammad A	Philadelphia
JAFARI, MD, Nercy	Lehigh
JAFFARI, MD, Mohammed A	Philadelphia
JAFFE, MD, Beryl	Philadelphia
JAFFE, MD, Joel D	Bucks
JAFFE, MD, John S	Lehigh
JAFFE, MD, Louis	Montgomery
JAFFE, MD, Marvin E	Philadelphia
JAFFE, MD, Seymour S	Warren
JAFFE, MD, Stephen C	Philadelphia
JAGEMAN, MD, James R	Erie
JAGEMAN, MD, John C	Erie
JAHDI, MD, Nasrollah	Allegheny
JAHNLE, MD, Richard L	Philadelphia
JAHRE, MD, Jeffrey A	Northampton
JAHROMI, MD, Heidar K	Chester
JAKAB, MD, Irene	Allegheny
JALALI, MD, Kuchak K	Centre
JALALI, MD, Manoucher	Delaware
JALBUENA, MD, Robert C	Delaware
JAMALI, MD, Anmar A	Delaware
JAMES, MD, Frank S	Philadelphia
JAMES, MD, Geoffrey M	Dauphin
JAMES, MD, Russell E	Luzerne
JAMESON, MD, E Carleton	Lancaster
JAMIL, MD, Qazi A	Mckean
JAMSHIDI, MD, Javad	Beaver
JAN, MD, Paula	Philadelphia
JAN, MD, Rehana A	Philadelphia
JAN, MD, Ronald S	Philadelphia
JAN, MD, Tayyaba S	Lackawanna
JANA, MD, Barid B	Fayette
JANA, MD, Dilip K	Erie
JANARDHANAN, MD, Ravi	Allegheny
JANERICH, MD, Albert D	Luzerne
JANEWAY, MD, Timothy	Allegheny
JANG, MD, Jang-Huei	Luzerne
JANIAK, DO, Daniel D	Allegheny
JANICIJEVIC, MD, Nenad	Allegheny
JANJIGIAN, MD, Edward R	Luzerne
JANNELLI, MD, Angela F	Bucks
JANNELLI, Dorothy F	Students
JANNETTA, Carol M	Allegheny
JANNETTA, MD, Peter J	Allegheny
JANOFF, MD, Barry A	Allegheny
JANOSKO, MD, Rudolph E	Allegheny
JANOWITZ, Michael J	Allegheny
JANSON, MD, Russell R	Delaware
JANZER, Sean F	Students
JAQUISS, MD, G William	Allegheny
JARGIELLO, Patricia	Allegheny
JARIWALA, MD, Leticia Q	Allegheny
JARMAN, MD, Martha L	Bucks
JARMOLOWSKI, MD, Chester R	Allegheny
JARRELL, MD, Bruce E	Philadelphia
JARRETT, MD, Fredric	Allegheny
JARVIS, MD, F Wayne	Philadelphia
JARYMOVYCH, MD, Jaroslaw I	Philadelphia
JAURIGUE, MD, Venerando G	Philadelphia
JAVAN, MD, Mehdi B	Westmoreland
JAVIAN JR, MD, Thomas A	Bucks
JAWAD, MD, Basil S	Chester
JAXHEIMER, MD, Eric C	Berks
JAY JR, MD, Wendell T	Berks
JAYAKUMAR, MD, Subramoniam	Washington
JEFFERIES III, MD, George E	Dauphin
JEFFERIS, MD, Tamar V	Montgomery
JEFFERS, MD, John B	Philadelphia
JEFFREY, MD, Mary E	Philadelphia
JEFFREYS, MD, William H	Montour
JEFFRIES, MD, Graham H	Dauphin
JELEN, MD, Joseph A	Philadelphia
JENCKES III, MD, George A	Berks
JENKINS, MD, B Wheeler	Philadelphia
JENKINS, MD, Benjamin C	Blair
JENKINS, MD, Jay L	Erie
JENKINS, Jody L	Students
JENKINS, MD, Timothy F	Delaware
JENKINS JR, MD, David E	Allegheny
JENKINS JR, MD, Robert J	Allegheny
JENNEY, MD, Florence S	Butler
JENNINGS, MD, David T	Lycoming
JENOFSKY, MD, Jack	Philadelphia
JENS, MD, Kurtis D	Lancaster
JENSVOLD, MD, Margaret F	Allegheny
JERMANOVICH, MD, Nancy B	Philadelphia
JESSAR, MD, Ralph A	Philadelphia
JETTER, MD, Walter W	Westmoreland
JETTI, MD, Krishna P	Allegheny
JEW JR, MD, Edward W	Allegheny
JEWELL, MD, Melanie	Philadelphia
JEWELL JR, MD, James H	Berks
JEWETT, MD, Stephen R	Lackawanna
JEYARAJ, MD, Francis	Montgomery
JHO, MD, Hae Dong	Allegheny
JIMENEZ, Fernando	Students
JIMERSON, MD, Cedric C	Berks
JIN, MD, Byunghak	Fayette
JOCHNOWITZ, MD, Michael J	Montgomery
JOEBSTL, MD, Barbara C	Philadelphia
JOEHL, MD, Raymond J	Dauphin
JOHAN, MD, Morton	Allegheny
JOHN, MD, Lawrence R	Allegheny
JOHN EXEC, DIR, Paul P	Lycoming
JOHNS, MD, Barbara A	Montour
JOHNS, MD, Milton W	Lancaster
JOHNSON, MD, Alfred T	Berks
JOHNSON, MD, Bernett L	Philadelphia
JOHNSON, MD, Carl G	Lancaster
JOHNSON, MD, Charles F	Lehigh
JOHNSON, Cherie J	Students
JOHNSON, MD, Craig H	Berks
JOHNSON, MD, Dennis R	York
JOHNSON, MD, Don E	Philadelphia
JOHNSON, MD, Dorothy E	Luzerne
JOHNSON, MD, Douglas E	Lehigh
JOHNSON, MD, Edwin M	Philadelphia
JOHNSON, MD, Elizabeth A	Philadelphia
JOHNSON, MD, Elting C	Bradford
JOHNSON, MD, Franklin P	Allegheny
JOHNSON, MD, Gary E	Allegheny
JOHNSON, MD, George M	York
JOHNSON, MD, Herbert C	Berks
JOHNSON, MD, James R	Allegheny
JOHNSON, MD, Jonas T	Allegheny
JOHNSON, MD, Max E	Beaver
JOHNSON, MD, Philip E P	Philadelphia
JOHNSON, MD, Rebecca W	Philadelphia
JOHNSON, MD, Robert B	Venango
JOHNSON, MD, Robert G	Philadelphia
JOHNSON, MD, Robert P	Lancaster
JOHNSON, MD, Van W	Warren
JOHNSON, MD, Waine C	Philadelphia
JOHNSON, MD, Walter K	Westmoreland
JOHNSON, MD, William T	Berks
JOHNSON, MD, Wm G	Northampton
JOHNSON, MD, Wm H	Philadelphia
JOHNSON III, MD, H John	Delaware
JOHNSON III, MD, S Harris	Allegheny
JOHNSON JR, MD, Bertram L	Lancaster
JOHNSON JR, MD, Howard J	Philadelphia
JOHNSON JR, MD, Marshall M	Allegheny
JOHNSON JR, MD, Thomas A	Philadelphia
JOHNSTON, MD, Dorothy	Schuylkill
JOHNSTON, MD, Eugene V	Lancaster
JOHNSTON, MD, Frank B	Philadelphia
JOHNSTON, DO, Harry D	Franklin
JOHNSTON, MD, J Murl	Allegheny
JOHNSTON, MD, James B	Venango
JOHNSTON, MD, James R	Allegheny
JOHNSTON, MD, Jean C	Philadelphia
JOHNSTON, MD, Russell M	Northumberland
JOHNSTON 3RD, MD, James R	Cumberland
JOHNSTON JR, MD, John A	Allegheny
JOHNSTONE, MD, Graham F	Allegheny
JOLLY, MD, Raj K	Elk/Cameron
JONAS, MD, Jaroslav G	Montour
JONES, MD, Ancil A	Delaware
JONES, MD, Bruce A	Chester
JONES, MD, C Henry	Lackawanna
JONES, MD, Daniel C	Montgomery
JONES, MD, David G	Lehigh
JONES, MD, David J	York
JONES, MD, Edward	Lebanon
JONES, MD, Edward L	Bradford
JONES, MD, Frederick L	Huntingdon
JONES, MD, George A	Dauphin
JONES, MD, George J	Washington
JONES, MD, J Albright	Delaware
JONES, MD, James E	Dauphin
JONES, MD, Joseph C	Adams
JONES, MD, Julie L	Lancaster
JONES, MD, Larry W	Blair
JONES, MD, Marion K	Berks
JONES, MD, Neil F	Allegheny
JONES, MD, Richard E	Adams
JONES, MD, Richard E	Beaver
JONES, MD, Robert K	Delaware
JONES, MD, Robert T	Luzerne
JONES, Seth M	Students
JONES, MD, Stuart A	Lehigh
JONES, MD, Terrence H	Lancaster
JONES, MD, Thomas D	Montour
JONES, MD, Tom B	Mercer
JONES, MD, W Mead	Montgomery
JONES, MD, Wendell E	Allegheny
JONES JR, MD, Arthur F	Lancaster
JONES JR, MD, Frederick L	Montour
JONES JR, MD, Harry B	Beaver
JONES JR, MD, John H	Lycoming
JONES JR, MD, Robert T	Allegheny
JONES-GORDON, Sandra M	Allegheny
JORDAN, MD, Claus G	Monroe
JORDAN, MD, Jerome W	Lackawanna
JORDAN, MD, William P	Monroe
JORDAN, MD, Wm J	Lackawanna
JORDAN JR, MD, Herbert V	Dauphin
JORET, MD, Dale M	Lackawanna
JOSEPH, MD, Alfred J	Mercer
JOSEPH, MD, Andrew H	Allegheny
JOSEPH, MD, Elaine R	Allegheny
JOSEPH, MD, George M	Northampton
JOSEPH, MD, Kadankavil C	Elk/Cameron
JOSEPH, DO, Mitchell W	Blair
JOSEPH, MD, Montefiore L	Allegheny
JOSEPH, MD, Raymond E	Philadelphia
JOSEPH, MD, Raymond J	Luzerne
JOSHI, MD, Harendra V	Philadelphia
JOSHI, MD, Kishor E	Fayette
JOSHI, MD, Kundabala S	Philadelphia
JOSHI, MD, Manohar J	Allegheny
JOSON, MD, Raymond M	Philadelphia
JOSSELSON, MD, Alan S	Montgomery
JOURDAIN, MD, Luis M	Blair
JOY, MD, Charles A	Erie
JOYCE, MD, Michael F	Montgomery
JOYCE, MD, Richard A	Dauphin
JOYCE III, MD, John J	Philadelphia
JOYNER, MD, David M	Dauphin
JOZEFCZYK, MD, Patricia B	Allegheny
JUANG, MD, Richard C	Erie
JUAREZ, MD, Rolando	Montgomery
JUBELIRER, MD, Robert A	Montgomery
JUDD, MD, Barry L	Allegheny
JUDD, MD, James D	Montgomery
JUDSON, MD, Susan C	Lycoming
JUDSON, MD, William W	Lycoming
JUHASZ, MD, Alex B	Indiana
JULES, MD, Arnold J	Montgomery
JULIA, MD, Ronald R	Northampton
JULIAN, MD, Thomas B	Allegheny
JULIUS, MD, Ernest L	Luzerne
JUNCOS, MD, Guillermo R	Chester
JUNEJA, MD, Damyanti	Philadelphia
JUNEJA, MD, Ish K	Philadelphia
JUNG, MD, Hong I	Lackawanna
JUNG, MD, Jay Soo	Lehigh
JUNG, MD, Jennifer L	Bucks
JUNG, MD, Tinliung	Mckean
JUNGHANS, MD, Siegfried P	Allegheny
JUNKIN, MD, David M	Montgomery
JUPIN, MD, John A	Venango
JURGENS, MD, Kenneth H	Erie
JURGENSEN, MD, John C	Cumberland
JURNOVOY, MD, Joel B	Delaware
JUSTIN, MD, Peter A	Northumberland
JUVELIER, MD, Bernard W	Dauphin

K

KAAR, MD, Richard C	Lycoming
KABLER, MD, Ronald L	Montour
KACHIK, MD, Larry J	Indiana
KACHLINE, DO, Donald A	Lackawanna
KACZOR, MD, Stanley F	Blair
KAFRISSEN, MD, Steven R	Luzerne
KAGUYUTAN, MD, Alfredo G	Adams
KAGUYUTAN, MD, Ofelia D	Adams
KAHN, MD, Bernard L	Philadelphia
KAHN, MD, Donald L	Philadelphia
KAHN, MD, Hyman R	Philadelphia
KAHN, MD, Ronald L	Bradford
KAHN, MD, Sigmund B	Philadelphia
KAHN, MD, Y Raymond	Armstrong
KAIN III, MD, Thomas M	Delaware
KAIRYS, MD, Leo R	Allegheny
KAISER, MD, Gerard D	Dauphin
KAISER, MD, Ralph H	Lycoming
KAISER, Robert M	Students
KAISLER, David M	Students
KAJANI, MD, Mehdi K	Philadelphia
KALAFER, MD, Marvin	Philadelphia
KALAGAYAN, MD, Hector J	Erie
KALAWADIA, MD, Vinodrai D	Montgomery
KALENAK, MD, Alexander	Dauphin
KALES, MD, Anthony	Dauphin
KALES, MD, Joyce	Dauphin
KALISH, MD, Robert W	Philadelphia
KALISH, MD, Sidney J	Philadelphia
KALKHOF, MD, Thomas C	Erie
KALKUNTE, MD, Jagdish R	Bradford
KALLA, MD, Richard L	Allegheny
KALLISH, MD, Marvin N	Philadelphia
KALLOZ, MD, John R	Adams
KALMANSON, MD, Jacob D	Allegheny
KALMAR, MD, Oscar R	Bucks
KALODNER, MD, Alfred L	Philadelphia
KALODNER, DO, David R	Delaware
KAMBIN, MD, Parviz	Philadelphia
KAMDAR, MD, Jayant C	Philadelphia
KAMEEN, MD, Anthony J	Luzerne
KAMERER, MD, Donald B	Allegheny
KAMINENI, MD, Uma	Philadelphia
KAMINSKI, MD, Robert J	Allegheny
KAMINSKI, MD, Thomas N	Westmoreland
KAMINSKY, MD, Anthony F	Erie
KAMINSKY, MD, James F	Erie
KAMINSTEIN, MD, David S	Chester
KAMMERER, MD, William S	Dauphin
KAMSLER, MD, David F	Adams
KANAL, MD, Emanuel	Allegheny
KANDRA, MD, Joseph J	Dauphin
KANDULA, MD, Ravindra R	Northampton
KANE, MD, Daniel M	Philadelphia
KANE, MD, James A	Lackawanna
KANE, MD, Joan D	Delaware
KANE, MD, John J	Allegheny
KANE, MD, John S	Montgomery
KANE, MD, Kevin M	Allegheny
KANE, MD, Michael J	Philadelphia
KANE, MD, Ruth P	Allegheny
KANE, MD, Wm M	Delaware
KANEFF, MD, Scott R	Northumberland
KANEFIELD, DO, Marvin	Philadelphia
KANEL, MD, Keith T	Allegheny
KANENSON, MD, William L	Dauphin
KANG, MD, Se-Boo	Armstrong
KANIA, MD, Robert J	Allegheny
KANIS, MD, Myron L	Philadelphia
KANN, MD, Jules	Allegheny
KANNAN, MD, Vaidehi	Delaware
KANNANGARA, MD, Yogeswary	Philadelphia
KANOFF, Steven J	Students
KANSAGRA, MD, Jasmat N	Cambria
KANSAL, MD, Kusum R	Blair
KANSAL, MD, Naren	Philadelphia
KANSAL, MD, Raj G	Blair
KANT, MD, Naval	Allegheny
KANT, MD, Nila N	Allegheny
KANTER, MD, Frank J	Philadelphia
KANTOR, MD, Milton	Luzerne
KAO, MD, Chien-Kuo	Allegheny
KAO, MD, Yu S	Luzerne
KAPADIA, MD, Dilip L	Delaware
KAPCALA, DO, Jan S	Monroe
KAPLAN, MD, Abraham	Monroe
KAPLAN, MD, Barry R G	Allegheny
KAPLAN, MD, Bernard	Philadelphia
KAPLAN, MD, Carl	Allegheny
KAPLAN, DO, Daniel B	Philadelphia
KAPLAN, MD, Frank E	Montgomery
KAPLAN, MD, Lawrence M	Berks
KAPLAN, MD, Louis	Philadelphia
KAPLAN, MD, Richard H	Philadelphia
KAPLAN, MD, Robert D	Philadelphia
KAPLAN, MD, Robin L	Berks
KAPLAN, MD, S Richard	Philadelphia
KAPLAN, MD, Sheldon J	Montour
KAPLAN, MD, Stephen M	Blair
KAPLOW, MD, Gwen H	Philadelphia
KAPOOR, MD, Rajeshwar D	Allegheny
KAPOOR, MD, Sarla	Clinton
KAPOOR, MD, Shailendra N	Clinton
KAPP, MD, Anton	Montgomery
KAPPAKAS, MD, George S	Allegheny
KAR, MD, Dilip S	Westmoreland
KARA, MD, Aoun B	Northampton
KARABELNIK, MD, Don	Berks
KARAFIN, MD, Lester	Philadelphia
KARAKASHIAN, MD, Nubar A	Philadelphia
KARAMANIAN, MD, Agop V	Erie
KARAMCHANDANI, MD, Nilima T	Allegheny
KARAMCHETI, MD, Anand	Washington
KARANJIA, MD, Minoo D	Indiana
KARASICK, MD, David	Philadelphia
KARASICK, MD, Sheldon R	Philadelphia
KARASICK, MD, Stephen	Philadelphia
KARBINER, MD, Helmut L	Montgomery
KARCSH, DO, Henry J	Chester
KARDISH, MD, Thomas J	Bucks
KARDUCK, MD, John S	Cambria
KAREHA, MD, Louis G	Lackawanna
KARETAS, MD, Alexandra I	Philadelphia
KARIAN, MD, John M	Venango
KARIMKHANI, MD, Kobra	Allegheny
KARLE, MD, John G	Erie
KARLIN, DO, Paul S	Philadelphia
KARMAZN, MD, Nelly	Philadelphia

KARMILOWICZ, MD, N Peter Philadelphia
KARNIK, MD, Subash S Bucks
KARP, MD, Joseph S Philadelphia
KARP, MD, Louis A Philadelphia
KARP, DO, Ronda G Montgomery
KARPEH JR, MD, Martin S Philadelphia
KARPIN, MD, Max Delaware
KARPINSKI JR, MD, Felix E Montgomery
KARPINSKI JR, MD, Stephen J Allegheny
KARR, MD, Steven P Allegheny
KARRON, MD, Betty Lehigh
KARSH, MD, Carl A Erie
KART, MD, Barry H Allegheny
KARUMBAYA, MD, Romola Lackawanna
KARUNARATNE, MD, Esiriwickreme Blair
KASALES, MD, Clarence J Lebanon
KASARDA, MD, Frances E Philadelphia
KASDAN, MD, Richard B Allegheny
KASDIN, MD, Sharon L Philadelphia
KASE, MD, James J Berks
KASE, MD, Paul F Dauphin
KASE, MD, Wm A Philadelphia
KASE JR, MD, James B Philadelphia
KASEFF, MD, Leon G Philadelphia
KASHATUS, MD, Wm C Philadelphia
KASHURBA, MD, Glenn J Philadelphia
KASI, MD, Krishnakumar A Beaver
KASPAR, MD, Albert J Northampton
KASPARIAN, MD, Hratch Philadelphia
KASPRENSKI, MD, Matthew A Lehigh
KASPRENSKI, MD, Matthew L Lehigh
KASPUTIS, MD, David A Columbia
KASRAIE, MD, Neptune Allegheny
KASSER, MD, Max D Philadelphia
KASTANEK, MD, Jill A Allegheny
KASTENBAUM, MD, Michael Berks
KASUMI, MD, Asao Lehigh
KATALAN, MD, Maurice M Philadelphia
KATES, MD, Malcolm Philadelphia
KATIGBAK, MD, Constancio D Westmoreland
KATLIC, MD, Mark R Luzerne
KATOWITZ, MD, James A Philadelphia
KATSAMPES, MD, Ernest T Dauphin
KATSETOS, MD, Christos D Allegheny
KATTELMAN, DO, Marc Montgomery
KATZ, MD, Alan S Philadelphia
KATZ, MD, Albert B Philadelphia
KATZ, MD, Benjamin R Philadelphia
KATZ, MD, David L Allegheny
KATZ, MD, Debra A Philadelphia
KATZ, MD, G Henry Philadelphia
KATZ, MD, Irving M Philadelphia
KATZ, MD, Irwin L Allegheny
KATZ, MD, Jacob Philadelphia
KATZ, MD, Janice D Philadelphia
KATZ, MD, Jerald M Westmoreland
KATZ, MD, Joseph Lancaster
KATZ, MD, Julian Philadelphia
KATZ, MD, Kathleen M Montgomery
KATZ, MD, M Richard Philadelphia
KATZ, MD, Max Philadelphia
KATZ, MD, Mitchell E Lehigh
KATZ, MD, Richard G Allegheny
KATZ, MD, Richard H Philadelphia
KATZ, MD, Robert E Montgomery
KATZ, MD, Sheila M Philadelphia
KATZ, MD, Steven A Delaware
KATZ, MD, Theodore T Philadelphia
KATZ, MD, Warren A Philadelphia
KATZIN, MD, Dick Allegheny
KATZMAN, MD, Jeffrey I Chester
KAUDERER JR, MD, John G Monroe
KAUFER, MD, Gerald I Allegheny
KAUFFMAN, MD, Abraham L Philadelphia
KAUFFMAN, MD, Chester T Indiana
KAUFFMAN, MD, M Luther Montgomery
KAUFMAN, MD, Abraham S Philadelphia
KAUFMAN, MD, Alan C Bucks
KAUFMAN, MD, Barre D Lehigh
KAUFMAN, MD, Benjamin V Lackawanna
KAUFMAN, MD, Jay H Lehigh
KAUFMANN, MD, Bruce M Northampton
KAUH, MD, Young C Philadelphia
KAUR, MD, Manjeet Lancaster
KAVIC, MD, Michael S Allegheny
KAVIC, MD, Thomas A Allegheny
KAVJIAN, MD, Edward M Delaware
KAVLE, MD, Carleton J Montgomery
KAWCHAK, MD, James Somerset
KAY, MD, Chester Allegheny
KAY, MD, Harold R Philadelphia
KAY, MD, Jonathan Philadelphia
KAY, MD, Lawrence E Allegheny
KAY, MD, Michael L Philadelphia
KAY, MD, Raymond J Montgomery
KAYE, MD, Donald Philadelphia
KAZEM, MD, Ismail Philadelphia
KAZI, MD, Sarwat A Berks
KEAGLE, DO, Douglas L Delaware
KEAGY, MD, R Marvel Blair
KEAN, MD, Dennis W Lehigh
KEAN, MD, Herbert Philadelphia
KEANE, MD, William M Philadelphia
KEARNEY, MD, John M Berks
KEARNEY, MD, Joseph A Westmoreland
KEARNS, MD, Joseph W Lancaster
KEATES, MD, Edwin U Philadelphia
KEATING, MD, Edward C Lycoming
KEBLISH JR, MD, Peter A Lehigh
KECK, MD, William S Westmoreland
KEDDIE, MD, Roland T Allegheny
KEECH JR, MD, Hayden G York
KEEFE, MD, Jerry M Lancaster
KEEFER, MD, George P Philadelphia
KEELY, MD, Elizabeth S Philadelphia
KEENAN, MD, Jeffrey A Allegheny
KEENEY, MD, Galen E Dauphin
KEEPORTS, MD, Richard L York
KEFFER, MD, William H Berks
KEGEL, MD, Daniel P Lancaster
KEGEL, MD, Eugene E Lancaster
KEHM, MD, Robert F York
KEHM, MD, Vincent A York
KEHRLI, MD, Henry J Lackawanna
KEHRLI, MD, William H Lackawanna
KEIL, MD, K Michael Philadelphia
KEIL, MD, Stephen M Centre
KEILANY, MD, Raghda T Philadelphia
KEIM, MD, Peter J Armstrong
KEISER, MD, Edwin L Berks
KEISER, MD, Lester Philadelphia
KEISERMAN, MD, Joseph Philadelphia
KEISMAN, MD, Robert A Philadelphia
KEISTER, MD, Stephen R Erie
KEITER, MD, James M Lebanon
KEITH, MD, Helen R H Northampton
KELBICK, MD, Elaine H Philadelphia
KELLER, Bradley B Students
KELLER, MD, Earl B Philadelphia
KELLER, MD, Eli J Berks
KELLER, MD, Frank M Allegheny
KELLER, MD, John E Berks
KELLER, DO, Jon M Lancaster
KELLER, MD, Lynwood V Berks
KELLERMAN, MD, Andrew D Allegheny
KELLERMAN, MD, Edwin Philadelphia
KELLEY, MD, Donald L Butler
KELLEY, Edward S Allegheny
KELLEY, MD, Glen D Allegheny
KELLEY JR, MD, Charles F Lehigh
KELLMAN, MD, Ian A Luzerne
KELLOGG, MD, Ronald A Crawford
KELLY, MD, Bruce R Allegheny
KELLY, MD, Edward A Delaware
KELLY, MD, Edward G Allegheny
KELLY, MD, Edward J Lackawanna
KELLY, MD, Eugene W Allegheny
KELLY, MD, Habib R Philadelphia
KELLY, MD, Herbert T Philadelphia
KELLY, MD, James J Delaware
KELLY, MD, John A Bradford
KELLY, MD, John L Delaware
KELLY, MD, John S Elk/Cameron
KELLY, MD, Kathleen P Philadelphia
KELLY, MD, Marianne L Lancaster
KELLY, MD, Michael G Allegheny
KELLY, MD, Paul O Delaware
KELLY, MD, Robert W Armstrong
KELLY, MD, Thomas J Allegheny
KELLY, MD, William E Philadelphia
KELLY, MD, William J Allegheny
KELLY JR, MD, Edward A Chester
KELLY JR, MD, John J Delaware
KELSEY, MD, David M Delaware
KELSO, MD, Don R Montgomery
KELTON, MD, Franklin C Montgomery
KELVIN, MD, Carl B Philadelphia
KEMP, MD, Gordon B Mercer
KEMP, MD, Robert M Lancaster
KEMP III, MD, Dewitt E Franklin
KEMPFE, MD, Konrad M Cumberland
KEMRER, MD, J Donald Lancaster
KENDALL, MD, A Richard Philadelphia
KENDALL, MD, Benjamin Philadelphia
KENDALL, MD, Leigh W Lancaster
KENEALY, James F X Students
KENIG, MD, Isador J Dauphin
KENKRE, MD, Sricrishna B Allegheny
KENNA, MD, Jos Patrick Lancaster
KENNA, MD, Marita D Allegheny
KENNARD, MD, John F Clearfield
KENNEDY, MD, F Bryan Allegheny
KENNEDY, MD, John N Luzerne
KENNEDY, MD, Nelson M Beaver
KENNEDY, MD, Patrick J Delaware
KENNEDY, MD, Peter S York
KENNEDY, MD, Richard P Monroe
KENNEDY, MD, Roland L Allegheny
KENNEDY, MD, Thomas L Montour
KENNEDY JR, MD, Carl H Philadelphia
KENNERDELL, MD, Edward H Allegheny
KENNERDELL, MD, John S Allegheny
KENNING, MD, James A Philadelphia
KENNY, MD, Kevin J Allegheny
KENT, MD, Carolyn D Franklin
KENT, MD, David W York
KENT, MD, George M Lancaster
KENT, MD, Richard B Chester
KENT, MD, W David Franklin
KENVIN, MD, John E Lehigh
KENWORTHY JR, MD, Harry J Montgomery
KEOHANE, MD, Richard B Philadelphia
KEON, MD, Thomas P Philadelphia
KEOSATHIT, MD, Narong Philadelphia
KEPHART, MD, Fred W York
KEPLER, MD, Furman T Delaware
KEPLER JR, MD, Walter E Delaware
KEPP, MD, Edward A Venango
KERBACHER, MD, Daniel J Columbia
KERN, MD, Frank Montgomery
KERN, MD, Franklin M Philadelphia
KERNICH, MD, Joseph J Jefferson
KERNIS, DO, David Philadelphia
KERR, MD, Paul B Susquehanna
KERR, MD, Robert M Luzerne
KERR, MD, Thomas M Philadelphia
KERR JR, MD, Clark M Westmoreland
KERR JR, MD, Harry J Allegheny
KERR JR, MD, Thomas Philadelphia
KERRIGAN, MD, James J Allegheny
KERRY, MD, Roy E Mercer
KERSHNER, MD, Marilyn S Berks
KERSON, MD, Lawrence A Montgomery
KERSTEEN EXEC, DIR, Duane E Luzerne
KERSTETTER, MD, David L Bedford
KERSTING, MD, John W Bradford
KESHGEGIAN, MD, Albert A Delaware
KESSEL, MD, Lawrence J Philadelphia
KESSELRING JR, MD, William T Monroe
KESSLER, MD, Frank J Northampton
KESSLER, MD, Laibe A Allegheny
KESSLER, MD, Martin J Philadelphia
KESSLER, MD, Otto F Allegheny
KESSLER, MD, Paul R Berks
KESSLER, MD, Rex K Delaware
KESSLER, MD, Woodrow B Delaware
KESTER, Kent E Students
KESTER, MD, Walter L Chester
KESZELI, MD, Alexander R Chester
KETELS, MD, Erk A Bucks
KETTERING, MD, Donald L Westmoreland
KETTRICK, MD, James P Luzerne
KETTRICK, MD, Robert G Philadelphia
KETZAN, MD, Tibor Montgomery
KEVENK, MD, Kerim C Cambria
KEVERLINE, MD, Paul O Warren
KEVITCH, MD, Robert B Philadelphia
KEYES, MD, Baldwin L Philadelphia
KEYES, MD, John W Lackawanna
KEYKHAH, MD, Mohammad M Philadelphia
KHADILKAR, MD, Vivek V Bucks
KHALAF, MD, Kamal Jefferson
KHALIFA, MD, Nagib M Franklin
KHALIL, MD, Karim Westmoreland
KHALILI, MD, Behrooz Allegheny
KHAN, MD, Abdul A Lehigh
KHAN, MD, Abu Philadelphia
KHAN, MD, Qador Philadelphia
KHAN, MD, Shaukat H Carbon
KHAN, MD, Sultan Schuylkill
KHANNA, MD, Chancal Philadelphia
KHANNA, MD, Om P Philadelphia
KHANNA, MD, Sudhir K Northumberland
KHANTHAN, MD, Subramaniam E Philadelphia
KHELLA, MD, Lewis Philadelphia
KHERA, MD, Dinesh C Erie
KHINDRI, MD, Chetan D Lehigh
KHOLOUSSY, MD, Abdelmohsen M Philadelphia
KHOSHBIN, MD, Bijan Lehigh
KHOURY, MD, Dennis J Philadelphia
KHOURY, MD, Jacques A Delaware
KHUBCHANDANI, MD, Indru T Lehigh
KHURANA, MD, Ramesh C Allegheny
KHWAJA, MD, Razaullah A York
KIBELSTIS, MD, John A Lehigh
KIBERT, MD, Leonard G Allegheny
KICHLER, MD, Joel M Allegheny
KIEFER, MD, Robert A Franklin
KIEFNER JR, MD, Frederick J Montgomery
KIEL, MD, Steven M Delaware
KIELMAN, MD, Michael J Allegheny
KIERNAN, DO, James V Philadelphia
KIESEL, MD, Robert Lehigh
KIESS, MD, Robt Christian Berks
KIKKAWA, MD, Kazutoshi Bradford
KILKENNY III, MD, John W Dauphin
KILLIAN, MD, Dorothea M Montgomery
KILLIAN, MD, Paul J Armstrong
KILLIAN III, MD, Calab L Berks
KILLIUS, MD, James L Somerset
KILMORE JR, MD, Vance E Dauphin
KILPATRICK, MD, Gertrude E Beaver
KILPATRICK, MD, William F Washington
KILPATRICK EXEC, SEC, William H Northampton
KILPELA, MD, Donald A Allegheny
KIM, MD, Achin Lancaster
KIM, MD, Chung H Lehigh
KIM, MD, Chung Shik Berks
KIM, MD, Dong H Westmoreland
KIM, MD, Dong H Fayette
KIM, MD, Doo T Northampton
KIM, MD, Eugene Y Allegheny
KIM, MD, Hack J Lancaster
KIM, MD, Hak R Bucks
KIM, MD, Hwan Y Cambria
KIM, MD, Hyoung D Allegheny
KIM, MD, Hyung-Bae Luzerne
KIM, MD, Ih C Northampton
KIM, MD, Ikjin Philadelphia
KIM, MD, Il G Lycoming
KIM, MD, Jae-Chil Allegheny
KIM, MD, Je H Lawrence
KIM, Jean Allegheny
KIM, MD, Jin I Lehigh
KIM, MD, Jung S Philadelphia
KIM, MD, Kun H Washington
KIM, MD, Kwan E Philadelphia
KIM, MD, Kyu S Lehigh
KIM, MD, Myoung S Fayette
KIM, MD, Philip Y Philadelphia
KIM, MD, Raymond Y Butler
KIM, MD, Sang M Jefferson
KIM, MD, Sangboum Philadelphia
KIM, MD, Scott S Allegheny
KIM, MD, Seong Montour
KIM, MD, Sun Choong Schuylkill
KIM, MD, Sung Y Allegheny
KIM, MD, Uh G Lawrence
KIM, Vivian T Students
KIM, MD, Wan J Lawrence
KIM, MD, Wha S Fayette
KIM, MD, Yang K Butler
KIM, MD, Yong Deok Allegheny
KIM, MD, Yong Il Westmoreland
KIM, MD, Yong S Philadelphia
KIM, MD, Yong Won Lancaster
KIM, MD, Yong-Kook A Philadelphia
KIM, MD, Yoon C Allegheny
KIM, MD, Young W Bucks
KIM, MD, Yung S Bucks
KIM, MD, Yung-Hoon Philadelphia
KIMBIRIS, MD, Demetrios G Philadelphia
KIMMEL, Craig S Students
KIMMEL, MD, Henry A Delaware
KIMMEL, MD, Murray H Philadelphia
KIMMELMAN, MD, Charles P Philadelphia
KING, MD, Andrew J Cambria
KING, MD, Arthur B Bradford
KING, MD, Arthur H Westmoreland
KING, MD, Barbara L Allegheny
KING, MD, Elmer S A Allegheny
KING, MD, Jane T Philadelphia
KING, MD, Joseph T Bradford
KING, MD, Leo M Allegheny
KING, MD, Lois I Philadelphia
KING, MD, Lorraine C Philadelphia
KING, Mary A Students
KING, MD, Phillip E Cambria
KING, MD, Robert L Allegheny
KING, MD, Roy J Erie
KING, MD, S Victor Blair
KING, MD, Weir L Berks
KINLAW, MD, W Bernard Montgomery
KINNEY, MD, Mary S Westmoreland
KINORI, MD, Ilan Philadelphia
KINOSIAN, MD, Mary J Venango
KINSEL, MD, Alvin A Allegheny
KINSEY, MD, Frank R Mifflin/Juniata
KINSEY, MD, Gary S Dauphin
KINTZEL, MD, James E Lehigh
KINTZER JR, MD, John S Northampton
KINTZI, MD, Harry E Lancaster
KIPP, MD, James E Lancaster
KIPROFF, MD, Paul M Allegheny
KIRALY, MD, Laszlo Lackawanna
KIRBER, MD, H Peter Philadelphia
KIRBY, MD, Claude W Cambria
KIRBY, MD, James E York
KIRCHHOFER, MD, Lewis H Delaware
KIRCHNER, MD, G Gary Lancaster
KIRK, MD, Daniel L Northumberland
KIRK, MD, H Zane Allegheny
KIRK, MD, Jacquelyn M Allegheny
KIRK, MD, Janet S Dauphin
KIRK, MD, Marvel S Lancaster
KIRK, MD, Norris J Lancaster
KIRKER JR, MD, Walter R Dauphin
KIRKLAND, Irene F Students
KIRKLAND, MD, Matt L Philadelphia
KIRKPATRICK, MD, Daniel W Montgomery
KIRKPATRICK, MD, Robert L Crawford
KIRKPATRICK, MD, Samuel A York
KIRKPATRICK JR, MD, David D Crawford
KIRSCH, MD, William J Blair
KIRSHBAUM, MD, Bernard A Philadelphia
KIRSHBAUM, MD, Gary R Philadelphia
KIRTLAND III, MD, Howard H Venango
KISH, MD, George F Erie
KISH, MD, Robert S Centre
KISLOFF, MD, Barry Allegheny
KISNER, MD, Robert G Allegheny
KISSELL, MD, Dewitt C Allegheny
KISTENMACHER, MD, John C Philadelphia
KISTLER, MD, Charles J Luzerne
KISTLER, MD, David W Luzerne
KISTLER, MD, Kermit K Lehigh
KISTLER, MD, Paul M Montgomery
KISTLER, MD, Philip E Chester
KISTLER, MD, Priscilla J Montgomery
KISTLER, MD, Warren D Franklin
KISTLER, MD, William S Montgomery
KITCHEN 2ND, MD, James G Monroe
KITCHEN 3D, MD, James G Delaware
KITEI, MD, Milton N Philadelphia
KITEI, MD, William J Northampton
KITSKO, DO, Dennis Washington
KITSKO, MD, William T Cambria
KITTLEBERGER, MD, William C Bucks
KITTRELL, MD, William H Washington
KITTS, MD, Ellen L Allegheny
KITZMILLER, MD, John K Dauphin
KIVITZ, MD, Alan J Blair
KIVULS, MD, Juris Philadelphia
KLAG, DO, Joseph V Allegheny

KLAIN, MD, Miroslav	Allegheny
KLASKO, MD, Stephen K	Lehigh
KLATCHKO, MD, William W	Lebanon
KLATMAN, MD, Samuel J	Allegheny
KLAVAN, MD, Marshall	Delaware
KLAWON, MD, David L	Erie
KLAY, MD, John W	Allegheny
KLEAVELAND, MD, Joseph P	Berks
KLECKNER, MD, Francis S	Lehigh
KLEES, MD, Athanasius	Lehigh
KLEIMAN, MD, Robert B	Philadelphia
KLEIN, MD, Dorothy E	Philadelphia
KLEIN, MD, Fred S	Washington
KLEIN, MD, Joseph F	Chester
KLEIN, MD, Joseph M	Luzerne
KLEIN, MD, Michael A	York
KLEIN, MD, Michael E	Dauphin
KLEIN, MD, Michael I	Allegheny
KLEIN, DO, Milton J	Allegheny
KLEIN, MD, Raymond A	Berks
KLEIN, MD, Richard M	Allegheny
KLEIN, MD, Robert	Columbia
KLEIN, MD, Rolf A	Venango
KLEIN, MD, Sanford M	Allegheny
KLEIN, MD, Sheldon	Philadelphia
KLEIN, DO, Steven G	Delaware
KLEIN, MD, Theodore C	Jefferson
KLEIN, MD, Thomas E	Philadelphia
KLEIN JR, MD, William J	Berks
KLEINBART, MD, Morris	Philadelphia
KLEINER, MD, Anton J	Berks
KLEINER, MD, Henry T	Philadelphia
KLEINER, MD, Jack	Philadelphia
KLEINERT, MD, Richard W	Centre
KLEINMAN, MD, Stuart B	Philadelphia
KLEINSCHMIDT, MD, Robert F	Allegheny
KLEM, MD, Albert J	Luzerne
KLEMEK, MD, Stanley C	Dauphin
KLEMENS, MD, Lee J	Cambria
KLEMENS, MD, Robert F	Cambria
KLEPPINGER, MD, Richard K	Berks
KLIEGER, MD, Herman L	Westmoreland
KLIGERMAN, MD, Morton M	Philadelphia
KLIGMAN, MD, Albert M	Philadelphia
KLIM, DO, Gerald V	Lycoming
KLIMES, MD, Ronald L	York
KLINE, MD, Ben	Lackawanna
KLINE, MD, Edgar W	Montgomery
KLINE, MD, Irwin K	Delaware
KLINE, MD, Jack A	York
KLINE, MD, Lewis R	Philadelphia
KLINE, MD, Robert M	Lebanon
KLINE, MD, Robert W	Allegheny
KLINE, MD, Tilde S	Delaware
KLINEFELTER, MD, Hylda C	Delaware
KLING, Maureen C	Students
KLINGENSMITH, MD, Walter C	Philadelphia
KLINGER, MD, Frank A	Venango
KLINGER, MD, Harry M	Montour
KLINGER, MD, James R	Philadelphia
KLINGHOFFER, MD, June F	Philadelphia
KLINGHOFFER, MD, Leonard	Philadelphia
KLINMAN, MD, Steven W	Philadelphia
KLINMAN, MD, William	Philadelphia
KLINZING, MD, Gerard F	Montgomery
KLIONSKY, MD, Bernard L	Allegheny
KLOIN, MD, Jay E	Lehigh
KLOSE, MD, Paul L	Somerset
KLOTZ, MD, Donald J	Lehigh
KLUFT, MD, Richard P	Berks
KLUTZ, MD, Joseph P	Allegheny
KMONICEK, MD, Joseph M	Philadelphia
KNAPP, MD, Michael A	Bucks
KNAPP, MD, Richard B	Greene
KNAPP, MD, Robert C	Allegheny
KNAPPENBERGER, MD, William L	Allegheny
KNAPPER, MD, Elizabeth J	Lehigh
KNAPPMAN, MD, John W	Berks
KNAUB, MD, Marilyn B	Delaware
KNECHT, MD, Charles L	Lehigh
KNEE, DO, Norman S	Philadelphia
KNEELAND, MD, Malcolm E	Montgomery
KNEIFATI, MD, Ahmed	Northumberland
KNELLER PHD EXEC, DIR, W Richard	Lackawanna
KNEPLEY, MD, David W	Columbia
KNEPP, MD, Mary E	Monroe
KNEPPER, MD, Joseph A	Lancaster
KNEPPER, MD, Laurie E	Allegheny
KNERR, MD, Richard A	Centre
KNERR JR, MD, Edgar D	Lancaster
KNIAZER, MD, Barry	Berks
KNIGHT, Alicia P	Students
KNIGHT, MD, Emma J	Allegheny
KNIGHT JR, MD, Emerson L	Dauphin
KNOCH, MD, H Roebling	York
KNOLL, MD, George M	Northampton
KNOTT, MD, Albert P	Allegheny
KNOUSE, MD, Albert B	Bucks
KNOWLES, MD, Harry J	Philadelphia
KNOWLES, MD, Willard E	Delaware
KNOWLTON JR, MD, Stephen B	Montgomery
KNOX, MD, Mark A	Centre
KNUPP, MD, Donna L	Allegheny
KNUPP, MD, Melvin L	Dauphin
KO, MD, Chan S	Schuylkill
KO, MD, Jehoon	Beaver
KO, MD, Yih S	Carbon
KO, MD, Yih Song	Mercer
KOBALY, MD, David J	Allegheny
KOBLIN, MD, Donald D	Dauphin
KOCH, MD, Andrew W	Lancaster
KOCH, MD, Joseph C	Allegheny
KOCH, MD, L Von	Lackawanna
KOCHU, MD, Steve	Berks
KODALI, MD, Raja V	Allegheny
KODSI, MD, Magdi S	Philadelphia
KODUMAL, MD, Luis E	Delaware
KOEHL JR, MD, C Warren	Luzerne
KOELLER, MD, Royal R	Cambria
KOELSCH, MD, Robert R	Bucks
KOENIG, MD, Hans	Allegheny
KOENIG, MD, Johann A	Luzerne
KOENIG, MD, Mark A	Allegheny
KOENIG, MD, Theodore R	Clarion
KOEPKE, MD, Hans H	Chester
KOEPSELL, MD, Don G	Philadelphia
KOERBER JR, MD, Walter A	Dauphin
KOFFLER, MD, David	Philadelphia
KOFFLER, MD, Howard B	Bucks
KOFLANOVICH, Susan E	Students
KOFSKY, MD, Phillip M	Philadelphia
KOGAN, MD, Allan J	Philadelphia
KOHAN, DO, David A	Lehigh
KOHL, MD, David H	Armstrong
KOHL, MD, E James	Philadelphia
KOHL, MD, Stephen D	Berks
KOHLER, MD, F Peter	Delaware
KOHLER, MD, Henry J	Philadelphia
KOHLER EXEC, SEC, Michael P	Cambria
KOHLHAS, MD, Jacob J	Montgomery
KOHRMAN, MD, Michael J	Allegheny
KOHRT, MD, Alan E	Wayne/Pike
KOHUTIAK, MD, Vsevolod	Delaware
KOIMATTUR, MD, Arwind	Allegheny
KOIVUNEN, MD, Debra G	Dauphin
KOIWAI, MD, Eichi K	Philadelphia
KOKALES, MD, John G	Allegheny
KOLANDER, MD, Scott A	Philadelphia
KOLANSKY, MD, Harold	Philadelphia
KOLB, MD, Aaron J	Lycoming
KOLB, MD, Charles E	Lycoming
KOLBER, MD, Lauren R	Philadelphia
KOLBYE, MD, Marion B	Philadelphia
KOLENICH, MD, James J	Mercer
KOLFF, MD, Jacob	Philadelphia
KOLTER, MD, James S	Chester
KOLTER JR, MD, Joseph P	Allegheny
KOLTES, MD, John A	Philadelphia
KOLTON, MD, Vladimir J	Berks
KOMALAHIRANYA, MD, Amnuay	Washington
KOMALAHIRANYA, MD, Usa E	Washington
KOMEN, MD, Supote S	Washington
KONCHANIN, MD, Lynn M	Bucks
KONCHAR, MD, William C	Montour
KONDASH, DO, Dennis J	Lackawanna
KONDAVEETI, MD, Kotayya	Allegheny
KONDRATOWSKI, MD, Richard Z	Philadelphia
KONDROT, MD, Edward C	Allegheny
KONECKE, MD, Lee L	Montgomery
KONECKE, MD, M Louis	Luzerne
KONECKE, MD, Ron J	Luzerne
KONHAUS, MD, Carol H	Dauphin
KONKOLY, Joanne	Students
KONRAD, MD, Mark G	Beaver
KONWINSKI, MD, Edward S	Mckean
KOO, MD, Peter J	Bucks
KOO, MD, Wook H	Luzerne
KOOLPE, MD, Harvey A	Philadelphia
KOOLPE, MD, Louis	Philadelphia
KOOROS, MD, Kian S	Allegheny
KOOSER, MD, Robert R	Allegheny
KOPACH, MD, Kathleen	Columbia
KOPEN, MD, Dan F	Luzerne
KOPENHAVER, MD, Donald B	Lehigh
KOPP, MD, Nel	Centre
KOPPEL, MD, Max M	Philadelphia
KOPROWSKA, MD, Irena	Philadelphia
KOPROWSKI, MD, Hilary	Philadelphia
KOPYCINSKI, MD, Clark F	Erie
KOPYT, DO, Nelson P	Lehigh
KORAT, MD, Orly C	Philadelphia
KORBONITS, MD, Charles W	Chester
KOREN, MD, Phillip A	Philadelphia
KORENTZWITT, MD, Edith	Philadelphia
KOREY, MD, Joseph J	Berks
KOREY, MD, Joseph J	Philadelphia
KORHAMMER, MD, Alan F	Northampton
KORINCHAK, MD, Jerome L	Mifflin/Juniata
KORMAN, MD, Michael J	Philadelphia
KORNELUK-REILLY, MD, Theresa	Philadelphia
KORT, MD, Joseph F	Northumberland
KORVICK, MD, Joyce A	Armstrong
KOSCO, MD, George M	Jefferson
KOSENSKE, Ted D	Allegheny
KOSHAR, MD, Mark I	Northampton
KOST, MD, Kenneth R	Armstrong
KOST, MD, Lewis V	Dauphin
KOST, MD, Paul F	Allegheny
KOST, Virginia L	Allegheny
KOSTER, MD, Lee H	Westmoreland
KOSTIN, MD, Raymond F	Dauphin
KOSTMAN, MD, Jay R	Philadelphia
KOSTYAL, MD, John L	Allegheny
KOTAKIS, MD, John	Philadelphia
KOTCH, MD, Michael J	Luzerne
KOTLOFF, MD, Leon	Philadelphia
KOTWAL, MD, Homi B	Philadelphia
KOTYO, MD, John A	Delaware
KOUGH, MD, Robert H	Montour
KOUKAL, MD, Ludwig R	Lawrence
KOUL, MD, Hira	Cambria
KOUSEN, MD, Morton	York
KOUTCHER, MD, Martin E	Philadelphia
KOVACS, MD, Donald J	Cumberland
KOVACS, MD, Robert J	Lehigh
KOVALSKY, MD, Don A	Philadelphia
KOVALSKY, MD, Evan S	Philadelphia
KOVALSKY, MD, Kenneth	Berks
KOVAR, MD, Charles E	Northampton
KOVATCH, MD, Anthony L	Allegheny
KOVELESKIE, Joseph R	Students
KOVEN, MD, Norman L	Philadelphia
KOWALLIS, MD, George F	Allegheny
KOWALSKI, MD, Joseph J	Luzerne
KOWALYSHYN, MD, Theodore J	Monroe
KOZAR, MD, Brian E	Dauphin
KOZART, MD, David M	Philadelphia
KOZICKY, MD, Peter W	Northampton
KOZIN, MD, William	Delaware
KOZINN, MD, Marc J	Lancaster
KOZINN, MD, Wesley P	Northampton
KOZIUPA, MD, Diana M	Bucks
KOZLEK, MD, Thomas F	Luzerne
KRABLIN, MD, Ronald	Adams
KRACKOW, MD, Joel A	Delaware
KRAEMER, MD, David W	Allegheny
KRAF, MD, Anastasia	Butler
KRAFCHIN, MD, Ira C	Lackawanna
KRAFTOWITZ, MD, Robert E	Allegheny
KRAH ASST EXEC, John G	Allegheny
KRAIN, MD, Raymond	Delaware
KRAK, MD, Michael	Allegheny
KRAK, MD, Michael D	Allegheny
KRAKOVITZ, MD, Jay A	Philadelphia
KRALJEVIC, MD, Juan E	Berks
KRALL, MD, J Thomas	Delaware
KRALL, MD, Robert P	Mckean
KRAM, DO, Barry W	Northampton
KRAM, MD, John E	Allegheny
KRAMER, MD, David J	Philadelphia
KRAMER, MD, Frederick L	Philadelphia
KRAMER, DO, Joel R	Philadelphia
KRAMER, MD, John B	Delaware
KRAMER, MD, Kenneth	Northampton
KRAMER, MD, Mark S	Philadelphia
KRAMER, MD, Randall K	Berks
KRAMER, MD, Selma	Philadelphia
KRAMER, MD, Simon	Philadelphia
KRANE, MD, Marvin A	Philadelphia
KRANIK, MD, Andrew D	Allegheny
KRANTZ, MD, Kathryn E	Philadelphia
KRANTZ, MD, Walter J	Montgomery
KRANTZLER, MD, Joseph D	Montgomery
KRASNOFF, MD, Sidney O	Philadelphia
KRATZ, MD, Vernon H	Bucks
KRATZER, MD, Glenn S	Lehigh
KRATZER, MD, Guy L	Lehigh
KRAUS, MD, David R	Allegheny
KRAUS, MD, John F	Allegheny
KRAUS, MD, Kathryn E	Beaver
KRAUS, MD, Theodore J	Philadelphia
KRAUSE, MD, Helen F	Allegheny
KRAUSE, MD, Jacob	Philadelphia
KRAUSE, MD, Norman M	Allegheny
KRAUSE, MD, Robert E	Lackawanna
KRAUSE, MD, Robert L	Philadelphia
KRAUSE, MD, Seymoure	Allegheny
KRAUSS, MD, Jack	Philadelphia
KRAUSZ, MD, Kathryn J	Northampton
KRAUSZ, MD, Marcos	Delaware
KRAUSZ, MD, Martin R	Philadelphia
KRAVIS, MD, Lillian P	Montgomery
KRAVITZ, MD, Bernard J	Montgomery
KRAVITZ, MD, Charles H	Philadelphia
KRAYBILL, MD, Harold E	Lancaster
KRAYER JR, MD, Nicholas H	Beaver
KRAYNICK, MD, Benjamin M	Lehigh
KREBS, MD, James A	Allegheny
KREBS, MD, Stephen J	Cumberland
KREGER, MD, Spencer	Cambria
KREGER JR, MD, Oliver J	Westmoreland
KREHL, MD, Willard A	Philadelphia
KREIDER, MD, Edward E	Lebanon
KREIDER, MD, Henry L	Lancaster
KREIDER, MD, John K	Lancaster
KREIDER, MD, John W	Dauphin
KREIDER, MD, Kathleen A	Lancaster
KREINBROOK, MD, Suzanne B	Allegheny
KREISER JR, MD, Joseph R	Dauphin
KREITHEN, MD, Harold	Lehigh
KRELL, MD, Arthur S	Cambria
KREMENS, MD, Victor	Philadelphia
KREMER, MD, Frederic B	Philadelphia
KREMER, MD, Howard U	Philadelphia
KREMER, DO, Stuart M	Montgomery
KREMSER, MD, Charles A	Allegheny
KRENIS, MD, Laurence J	Philadelphia
KRENZEL, MD, Archibald R	Philadelphia
KRESGE, MD, Dale L	York
KRESH, MD, Norman N	Allegheny
KRESOCK JR, MD, Frank D	Montour
KRESSLER, MD, Robert J	Philadelphia
KRETZ, MD, Stewart F	Allegheny
KRETZING, MD, Harold G	Cumberland
KREULEN, MD, Thomas H	Philadelphia
KREVOLIN, DO, Larry E	Philadelphia
KREVSKY, MD, Benjamin	Philadelphia
KREW, MD, Michael A	Allegheny
KRICUN, MD, Morrison E	Philadelphia
KRICUN, MD, Robert	Lehigh
KRIEBEL, MD, Dorothy E	Berks
KRIEBEL, MD, Richard H	Bucks
KRIEGER, MD, Benson	Philadelphia
KRIEGER, MD, Harry L	Northampton
KRIEGER, MD, Steven M	York
KRIFCHER, MD, Emanuel	Allegheny
KRING, MD, Carroll S	Berks
KRINSKY, MD, Sam Irwin	Cambria
KRISANDA, MD, Joseph B	Lackawanna
KRISCH, MD, Ronald A	Lehigh
KRISHNA, MD, Bhupendra	Chester
KRISHNA, MD, Narendra	Chester
KRISHNAN, MD, Geeta	Columbia
KRISHNAN, MD, Kalyan S	Montour
KRISHNAN, MD, R G	Allegheny
KRISHNAPPA, MD, Boriah N	Westmoreland
KRISHNASWAMI, MD, Subramania	Allegheny
KRISHNASWAMI, MD, V	Allegheny
KRISSINGER, MD, Robert C	Lancaster
KRISTO, MD, Catherine V	Delaware
KRISTOFIC, MD, John D	Allegheny
KRIVENKO, MD, Charles A	Luzerne
KRIVINKO, MD, Dennis M	Allegheny
KROEGER, MD, Hilda H	Allegheny
KROEMER, MD, Peter O	Erie
KROLL, MD, Robin	Philadelphia
KROMASH, MD, Marvin H	Montgomery
KRON, MD, Ira B	Blair
KRON, MD, Kenneth M	Philadelphia
KRON, MD, Samuel D	Philadelphia
KROSER, MD, Albert S	Philadelphia
KROSER, MD, Lila S	Philadelphia
KROSNICK, Jody A	Students
KROSNOFF, MD, Michael	Washington
KROSS, MD, Dean E	Allegheny
KROTEC, MD, Joseph W	Philadelphia
KROTEC, MD, Joseph W	Allegheny
KROUSE, MD, John M	Westmoreland
KRUEGER, MD, Cory S	Philadelphia
KRUG, MD, Edgar S	Centre
KRUG III, MD, E Clyde	Allegheny
KRUGH, MD, Francis J	Allegheny
KRUGH, MD, James W	Allegheny
KRUPER, MD, John S	York
KRUSEN, MD, David E	Lancaster
KRUSZEWSKI, MD, Stefan P	Cambria
KRYWICKI, MD, William J	Luzerne
KRZYWICKI, MD, Paul L	Philadelphia
KSIAZEK, MD, Susan M	Philadelphia
KU, MD, Andrew	Philadelphia
KUBEK, MD, John A	Northampton
KUBER, MD, Matthew E	Philadelphia
KUBIAK, MD, Richard V	Philadelphia
KUCER, MD, Frank T	Bucks
KUCER, MD, Kathleen A	Bucks
KUCHARCZUK, MD, John B	Lehigh
KUHN, MD, Richard H	Erie
KUHNEN, MD, Walter H	Warren
KUHNLEY, MD, Edward J	Centre
KUITEMS, MD, Frank D	York
KUKLINSKI, MD, Lawrence M	Erie
KUKRIKA, MD, Miodrag D	York
KULBASKI, MD, Frank E	Luzerne
KULCZYCKI, MD, Edward	Bradford
KULKARNI, MD, Pradeep K	Cambria
KULLING, MD, David L	Clearfield
KULP, MD, Jeffrey T	Philadelphia
KUMAR, MD, Ashok	Washington
KUMAR, MD, Harinath V	Venango
KUMAR, MD, Prem	Butler
KUMAR, MD, Rama V	Westmoreland
KUMAR, MD, V Hema	Westmoreland
KUMAR, MD, Vasantha R	Philadelphia
KUMAR, MD, Veerandra	Philadelphia
KUN, MD, Joseph	Allegheny
KUNDA, MD, Gopal D	Westmoreland
KUNDU, MD, Sambhu N	Dauphin
KUNG, MD, Luke C	Northampton
KUNKEL, MD, Barbara K	Dauphin
KUNKEL, MD, George A	Fayette
KUNKEL, MD, George W	Dauphin
KUNKEL, MD, Herbert G	Allegheny
KUNKEL, MD, James V	Allegheny
KUNKEL, MD, Mary E	Fayette
KUNKEL, MD, W Minster	Dauphin
KUNKEL, MD, William H	Allegheny
KUNKEL JR, MD, Herbert G	Allegheny
KUNSCHNER, MD, Alan J	Allegheny
KUNSCHNER, MD, Albert J	Allegheny
KUNSMAN, MD, William E	Allegheny
KUNZ, Robert A	Students
KUPERSMITH, MD, Stephen J	Bucks
KUPFER, MD, Samuel	Allegheny
KUPP, MD, John H	Carbon
KUPREVICH, DO, William J	Columbia
KURELLO, MD, Phillip J	Luzerne
KUREMSKY, MD, Dale A	Allegheny
KUREY, MD, Robert J	Lancaster
KURIAN, MD, Santhamma	Blair
KURIC, Kevin M	Students

KURTZ, MD, Alfred B	Philadelphia
KURTZ, MD, Charles H	Lancaster
KURTZ, MD, J Stephen	Philadelphia
KURTZ, MD, John E	Allegheny
KURTZ, MD, Michael B	Delaware
KURZ, MD, Richard B	York
KURZ, MD, Susan D	York
KUSH, MD, Frank H	Allegheny
KUSH, MD, Margaret B	Allegheny
KUSHNER, MD, Bertrand	Dauphin
KUSHNER, MD, Lois N	York
KUSHNER, DO, Paul G	Montgomery
KUSHNER JR, MD, George	York
KUSIAK, MD, Joseph F	Philadelphia
KUSIAK, MD, Victoria M	Philadelphia
KUSKIN, MD, Louis F	Dauphin
KUSSMAUL, MD, William G	Berks
KUTALEK, MD, Steven P	Philadelphia
KUTNEY, MD, Francis G	Delaware
KUTSCHER, MD, Harlan A	Berks
KUTSENKOW, MD, Michael	Allegheny
KUTTY, MD, Ahmed C	Philadelphia
KUTZ, MD, Charles M	Clarion
KUTZ, MD, Eugene R	Bedford
KUZMA, MD, Mary Ann	Philadelphia
KUZMA, MD, Paul M	Beaver
KWA, MD, Daniel M	Philadelphia
KWA, Linda A	Allegheny
KWAPIEN, MD, Frederic J	Delaware
KWEI, MD, Josephine M	Allegheny
KYLE, MD, G Clayton	Philadelphia
KYNE, MD, Peter J	Allegheny
KYRCZ, MD, Robert W	Philadelphia
KYREAGES, MD, Constantine G	Allegheny
KYRIACOPOULOS, MD, John D	Allegheny

L

LABBATE, MD, Victor A	Luzerne
LABE, MD, Alexander	Philadelphia
LABORDA, MD, Oscar E	Delaware
LABORDE, Andrea T	Students
LABOWSKIE, MD, Eugene M	Montgomery
LABUDA II, MD, Joseph M	Westmoreland
LABUZ, MD, Eugene F	Luzerne
LACAVARO, MD, Jules A	Delaware
LACE, MD, Thomas E	Westmoreland
LACHMAN, MD, Bernard E	Lehigh
LACHMAN, MD, John W	Philadelphia
LACHMAN, MD, Joseph	Delaware
LACHMAN, MD, Martin J	Philadelphia
LACHMAN, MD, Robert J	Montgomery
LACOUTURE, MD, Luis	Allegheny
LACZI, MD, Bartolomeu J	Delaware
LADANI, MD, Chhaganlal D	Allegheny
LADDA, MD, Roger L	Dauphin
LADDEN, MD, John J	Philadelphia
LADDEN, MD, Paul A	Philadelphia
LADENHEIM, MD, Steven E	Philadelphia
LADO, MD, Michael	Schuylkill
LADO, Michael D	Students
LAFOLLETTE, MD, Bruce F	Montour
LAFONTAINE, MD, Mildred H	Philadelphia
LAFONTANT, MD, Raymond F	Philadelphia
LAFONTANT, MD, Robert R	Westmoreland
LAGRIMAS, MD, Fernando C	Northumberland
LAGUNILLA, MD, Juanito L	Montgomery
LAIGON, MD, Eugene E	Carbon
LAIGON JR, MD, Eugene E	Schuylkill
LAING, MD, Patrick G	Allegheny
LAIRD, MD, Archibald	Tioga
LAKATOS, MD, Nicholas R	Luzerne
LAKDAWALA, MD, Shabbir	Allegheny
LAKOVICS, MD, Magnus	Centre
LALLY, MD, Francis L	Mercer
LALLY, MD, Michael E	Allegheny
LALLY, MD, Patrick T	Westmoreland
LALUNA, MD, Francis J	Lackawanna
LAM, MD, Carl A	Lehigh
LAM, MD, Tony C	Philadelphia
LAMADE, MD, Charles D	Montour
LAMAN JR, MD, Paul D	Allegheny
LAMANNA, MD, John V	Berks
LAMANNA, MD, Margaret M	Philadelphia
LAMARQUE, MD, Edward E	Dauphin
LAMAS, MD, Carlos C	Allegheny
LAMBERG, MD, Randy E	Philadelphia
LAMBERT, MD, Barbara A	Philadelphia
LAMBERT, MD, Kenneth P	Berks
LAMBERT, MD, Robert L	Philadelphia
LAMBERTI, MD, William F	Lackawanna
LAMBERTON, MD, William D	Erie
LAMBERTON, MD, William F	Erie
LAMBERTSEN, MD, Christian J	Philadelphia
LAMBICHI, MD, Marika E	Delaware
LAMBROS, MD, John E	Bucks
LAMBROU, MD, Peter J	Beaver
LAME, MD, Edwin L	Philadelphia
LAMON, MD, Charles P	York
LAMP, MD, Albert L	Erie
LAMP JR, MD, Clyde B	Allegheny
LAMPE, MD, William T	Philadelphia
LAMPE II, MD, William T	York
LAMPERSKI, MD, Curtis R	Allegheny
LAMPERSKI, MD, Lloyd G	Allegheny
LAMSBACK, MD, Edward G	Philadelphia
LAN, MD, Sung-Shu	Indiana
LANAUZE, MD, Harry E	Allegheny
LANCASTER JR, MD, Edward L	Lancaster
LAND, MD, Alfred J	Schuylkill
LANDAU, MD, Leo W	Luzerne
LANDAU, MD, Philip M	Allegheny
LANDAU, MD, Richard E	Philadelphia
LANDAY, MD, Louis H	Allegheny
LANDAY, MD, Ronald A	Allegheny
LANDER, MD, Jeffrey R	York
LANDER, MD, William W	Montgomery
LANDERMAN, MD, Nathaniel S	Allegheny
LANDES, MD, Ray P	Bucks
LANDFAIR, MD, Roy J	Allegheny
LANDIS, MD, Floyd M	Lancaster
LANDIS, MD, Ray L	Wyoming
LANDIS, MD, Richard M	Lancaster
LANDIS, MD, Robert C	York
LANDOLT, MD, Dolores M	Venango
LANDON JR, MD, Lyndon H	Allegheny
LANDSBERG, MD, Marc A	Philadelphia
LANDY, MD, Jules E	Allegheny
LANE, MD, Charles D	Berks
LANE, MD, John D	Bucks
LANE, MD, John F	Washington
LANE, MD, Sally D	Philadelphia
LANG, MD, Gregory M	Lehigh
LANG, MD, Howard N	Allegheny
LANG, MD, Kathie J	Union
LANG, MD, Nikki	Philadelphia
LANG, MD, Stanley	Jefferson
LANG, MD, Warren R	Philadelphia
LANGAN 3D, MD, E Lawrence	Delaware
LANGE, MD, John A	Erie
LANGENHEIM, MD, Geosette A	Washington
LANGER, MD, D Morton	York
LANGFELD, MD, Stephen B	Philadelphia
LANGFITT, MD, Thomas W	Philadelphia
LANGFORD, MD, Mark M	Allegheny
LANGOL JR, MD, George	Allegheny
LANGON, MD, James	Schuylkill
LANGSTON, MD, William C	York
LANOCE, MD, Louis F	Philadelphia
LANSDALE, MD, Thomas F	York
LANSHE, MD, Harold F	Dauphin
LANSING, MD, Dorothy I	Chester
LANTOS, MD, Raymond J	Cambria
LANZ, MD, Richard K	Allegheny
LANZ JR, MD, Robert J	Allegheny
LAPAYOWKER, MD, Marc S	Philadelphia
LAPE JR, MD, I Samuel	Lebanon
LAPES, MD, George A	York
LARA, MD, Henry R	Erie
LARACH, MD, David R	Dauphin
LAREAU, MD, Daniel G	Warren
LARGE, MD, Fred D	Washington
LARGE, MD, Hiram S	Northampton
LARGOZA, MD, Nacianceno T	Philadelphia
LARKIN, MD, Francis L	Fayette
LARKIN, MD, Frank L	Lackawanna
LARKIN, MD, Michael J	Lawrence
LARKIN, MD, Walter J	Lackawanna
LARKIN, MD, William A	Fayette
LARKIN JR, MD, Vincent D	Lackawanna
LARKIN JR, MD, Walter J	Lackawanna
LARNED, MD, Greer G	Philadelphia
LAROSSA, MD, Donato D	Philadelphia
LARRIEU, MD, Alberto J	Philadelphia
LARSEN, MD, Kenneth D	Philadelphia
LARSON, Christopher E	Allegheny
LARSON, MD, Eleanor	Tioga
LARSON, MD, James H	Crawford
LARSON JR, MD, Theodore S	Lycoming
LARTZ, MD, Robert E	Mercer
LASALVIA, MD, Lucy A	Philadelphia
LASCHEID, MD, William P	Allegheny
LASHER, MD, J Donald	Erie
LASHER, MD, Robert L	Erie
LASKA, MD, Edward M	Delaware
LASKAS, MD, John J	Delaware
LASKAS JR, MD, John J	Delaware
LASKIN, MD, Isadore	Philadelphia
LASKOWSKI, MD, Robert J	Montgomery
LASTICK, MD, Samuel G	Philadelphia
LATMAN, MD, Stephen F	Berks
LATOFF, MD, Thomas J	Chester
LATOUR, MD, Frantz	Philadelphia
LATOUR, MD, Marie G	Philadelphia
LATSHAW, MD, Robert F	Lancaster
LATTA, Richard A	Students
LATTANAND, MD, Saowanee	Delaware
LATTIMER, MD, Gary L	Lycoming
LATTIN, MD, Gary M	Berks
LATUSKA, MD, Richard F	Allegheny
LATZKO, MD, Paul J	Dauphin
LAUANDOS, MD, Ibrahim E	Philadelphia
LAUB, MD, Curtis H	Crawford
LAUB, MD, Irene F	Northampton
LAUBACH, MD, George B	Northampton
LAUBACH JR, MD, Charles A	Montour
LAUBY, MD, Vincent W	Philadelphia
LAUCIUS, MD, J Frederick	Philadelphia
LAUCKS, MD, S Philip	York
LAUCKS, MD, Stephen O	York
LAUCKS II, MD, Samuel S	York
LAUDENSLAGER, MD, Elmer C	Bucks
LAUFE, MD, Martin B	Philadelphia
LAUFER, MD, Elizabeth U	Philadelphia
LAUFER, MD, Fred	Lehigh
LAUKAITIS, MD, Ronald B	Lancaster
LAUREANO, MD, Reynaldo E	Butler
LAURY, MD, William L	Philadelphia
LAUTERBACH, MD, Edwin W	Montgomery
LAUTZ, MD, Virginia H	Philadelphia
LAVAN, MD, Donald W	Philadelphia
LAVAY, MD, Donald E	Crawford
LAVER, MD, Arthur T	Delaware
LAVERAN STIEBER, MD, Rudolf F	Philadelphia
LAVERDE, MD, Philip S	Venango
LAVIN, MD, David M	Erie
LAVIN, DO, Edwin	Philadelphia
LAVIN, MD, Morris	Philadelphia
LAVIN-LESKA, MD, Linda S	Bucks
LAVORGNA, MD, Kathleen A	Philadelphia
LAWLESS, MD, David F	Cambria
LAWLESS, MD, Grant D	Allegheny
LAWLOR, MD, John M	Philadelphia
LAWLOR, MD, Robert J	Montgomery
LAWRENCE, MD, James B	Philadelphia
LAWRENCE, MD, John W	Delaware
LAWRENCE, MD, Salvatore A	Lackawanna
LAWRENCE JR, MD, Slavatore A	Philadelphia
LAWSKY, MD, Alan R	Allegheny
LAWSON, MD, Alton L	Allegheny
LAWSON JR, MD, Herman	Dauphin
LAWVENCE, Steven J	Students
LAYCHOCK, MD, Anna M	Dauphin
LAYDEN, MD, Paul W	Erie
LAYMAN, MD, Richard P	Franklin
LAYTON, MD, Bradley W	Wayne/Pike
LAZAR, MD, Richard J	Luzerne
LAZARO, MD, Miguela D	Philadelphia
LAZARUS, DO, Ben G	Lancaster
LAZARUS, MD, Gerald S	Philadelphia
LAZO, MD, Alfonso	Franklin
LAZORIK, MD, Francis C	Delaware
LE, MD, Danh V	Washington
LE, MD, Loc Kim	Allegheny
LEAHY, MD, Joann M	Philadelphia
LEAHY, MD, John J	Philadelphia
LEAL, MD, Gumersindo R	Schuylkill
LEAMAN, MD, David M	Dauphin
LEAMAN, MD, Ivan B	Lancaster
LEAMAN, MD, Phyllis L	Lancaster
LEAR, MD, Benjamin F	Armstrong
LEAR, MD, William L	Indiana
LEARNER, MD, Norman	Philadelphia
LEASE, MD, John R	Luzerne
LEASER, MD, Joseph P	Dauphin
LEAVITT, MD, Herbert M	Northampton
LEBEAU, MD, Jack	Montgomery
LEBED, DO, Joel P	Philadelphia
LEBER, MD, David C	Dauphin
LEBER, MD, Paul E	Lycoming
LEBERMAN, MD, Paul R	Philadelphia
LEBISCHAK, MD, Peter H	Delaware
LEBMAN, MD, Ronald I	Philadelphia
LEBO, MD, Arland A	Lancaster
LEBOUITZ, MD, Stanton S	York
LEBOVITZ, MD, Allen E	Allegheny
LEBOVITZ, MD, Charles N	Allegheny
LEBOVITZ, MD, Jerome J	Allegheny
LECHER, MD, Robert C	Delaware
LECHMAN, MD, Michael J	Delaware
LECHMANICK, MD, Eugene A	Allegheny
LECHNER, MD, Frederic C	Lycoming
LECKS, MD, Harold I	Montgomery
LECKS, MD, Leonard E	Philadelphia
LEDIS, MD, Robert	Philadelphia
LEDIS, MD, Seymour	Bucks
LEE, MD, Bernard L	Philadelphia
LEE, MD, Bong S	Philadelphia
LEE, MD, Chanchi	Bucks
LEE, MD, Charles Y	Delaware
LEE, MD, Chong K	Montour
LEE, MD, Chong S	Lehigh
LEE, MD, Chung H	Carbon
LEE, MD, Dong P	Erie
LEE, MD, Edward Y	Lackawanna
LEE, MD, Ferrol J	Bradford
LEE, MD, Foo T	Allegheny
LEE, MD, H C	Northampton
LEE, MD, Henry F	Philadelphia
LEE, MD, Howard G	Chester
LEE, MD, In W	Erie
LEE, MD, James J	Allegheny
LEE, MD, Jangwoo	Schuylkill
LEE, MD, John K	Washington
LEE, MD, Jong Y	Westmoreland
LEE, MD, Jung S	Berks
LEE, MD, Jung-Pil	Berks
LEE, MD, Kee C	Lancaster
LEE, MD, Keun Sang	Allegheny
LEE, MD, Ki B	Luzerne
LEE, MD, Kwan I	Allegheny
LEE, MD, Kwang W	Philadelphia
LEE, MD, Kyung C	Lackawanna
LEE, MD, Kyung Yun	Huntingdon
LEE, MD, Martin L	Montour
LEE, MD, Ook J	Allegheny
LEE, MD, Robert E	Allegheny
LEE, MD, Rotan	Philadelphia
LEE, MD, Sang T	Northampton
LEE, MD, Sangeui L	Allegheny
LEE, MD, Stephen E	Allegheny
LEE, MD, Won Y	Schuylkill
LEE, MD, Ying P	Fayette
LEE, MD, Young W	Wayne/Pike
LEE JR, MD, Charles T	Philadelphia
LEE JR, MD, James H	Philadelphia
LEECH, MD, John W	Allegheny
LEEDHAM, MD, Charles L	Dauphin
LEEGARD, MD, Robert L	Philadelphia
LEEN, MD, Raymond L	Allegheny
LEET, MD, Thomas E	Lehigh
LEFEVER, MD, Gerald S	Philadelphia
LEFEVER, MD, Robert S	Adams
LEFF, MD, Bernard	Allegheny
LEFKOE, MD, Roy T	Philadelphia
LEFKOE, Todd P	Students
LEFLER, MD, Kenneth D	Cambria
LEFTON, MD, Harvey B	Philadelphia
LEGENDRE, MD, Gerald M	Montgomery
LEGUM, MD, Ronald M	Lancaster
LEHAR, Sarah C	Allegheny
LEHMAN, MD, Clara M	Allegheny
LEHMAN, MD, Clinton J	Luzerne
LEHMAN, DO, Gregory M	Delaware
LEHMAN, MD, Harvey L	Lancaster
LEHMAN, MD, John W	Beaver
LEHMAN, MD, Nelson R	Lancaster
LEHMAN, MD, Ralph A	Dauphin
LEHMAN, MD, Ruby V	Dauphin
LEHRER, MD, Lewis	Philadelphia
LEHRER, Luisa E	Students
LEHRICH, MD, Henry E	Lehigh
LEIBOWITZ, MD, Helen A	Delaware
LEIBOWITZ, MD, Leonard D	Allegheny
LEIBY, MD, David K	Bucks
LEICHT, MD, Michael J	Montour
LEIDER, MD, Harry L	Philadelphia
LEIGH, MD, Flora B	Delaware
LEIGH, MD, Rewng	Westmoreland
LEIGHTON, MD, Joseph	Philadelphia
LEIGHTY, MD, Ralph G	Somerset
LEIMAN, MD, Paul M	Lackawanna
LEINBACH JR, MD, Harvey D	Berks
LEINER, MD, Seymour	Montgomery
LEIPHART, MD, Clarence D	Lancaster
LEIPOLD, MD, Robert W	Montour
LEIS, MD, Dean J	Dauphin
LEISAWITZ, MD, Elliott G	Berks
LEISAWITZ, MD, Paul A	Berks
LEISE, MD, Eleanor O	Delaware
LEISTER, MD, C Merrill	Lehigh
LEISTER, MD, Howard A	Bucks
LEITEL, MD, Harold L	Jefferson
LEITNER, MD, Kermit L	Dauphin
LEITNER, MD, Stephen J	Delaware
LEKAWA, MD, Thaddeus	York
LEMAN, MD, William W	Delaware
LEMASTERS, DO, Thomas R	Schuylkill
LEMENTOWSKI, MD, Michal	Fayette
LEMERT, MD, Michael R	Chester
LEMLEY, MD, Diana K	Allegheny
LEMMON JR, MD, William T	Philadelphia
LEMOLE, MD, Gerald M	Philadelphia
LEMON, MD, Arden N	Philadelphia
LEMONCELLI, MD, Gary L	Allegheny
LEMOS, Mark J	Students
LEMPERT, MD, Steven L	Allegheny
LENAHAN, MD, Paul J	Luzerne
LENCHNER, MD, Gregory S	Philadelphia
LENGEL, MD, Gary P	Berks
LENKEY, MD, Joseph L	Allegheny
LENKO, MD, Philip M	York
LENNERT, MD, Joseph B	Northampton
LENOX, MD, Cora C	Allegheny
LENOX, MD, John E	Allegheny
LENOX, MD, Robert J	Bradford
LENTINI, MD, J Charles	Luzerne
LENTINI, MD, Joseph A	Luzerne
LENTON, MD, Herbert P	Cumberland
LENTZ, MD, Conrad L	Northampton
LENTZ, MD, John W	Philadelphia
LENTZ, MD, Kenneth H	Allegheny
LENTZ, Mark R	Students
LENTZ, MD, Robert E	Lehigh
LENYO, MD, George E	Luzerne
LEO, MD, Louis R	Philadelphia
LEON, MD, Donald F	Allegheny
LEON, MD, Federico G	Dauphin
LEONARD, MD, Michael E	Susquehanna
LEONARD JR, MD, Edward C	Philadelphia
LEONE, MD, Charles R	Erie
LEONE, MD, Guy R	Westmoreland
LEONI, MD, Joseph	Berks
LEONIDA, MD, Elfren L	Westmoreland
LEOPOLD, DO, Norman A	Delaware
LEOPOLD, MD, Robert L	Philadelphia
LEOPOLD JR, MD, A Reid	Mifflin/Juniata
LEPAR, MD, Edwin	Philadelphia
LERBERG, MD, David B	Allegheny
LERNER, Guy M	Allegheny
LERNER, MD, Harvey J	Philadelphia
LERNER, Jodi P	Students
LERNER, MD, Samuel M	Lehigh
LERNER, MD, Sidney S	Philadelphia
LEROY, MD, N Blair	Montgomery
LESHOCK, MD, Leon E	Carbon
LESLIE, MD, David C	Washington
LESLIE JR, MD, M Russell	Allegheny
LESNIAK, MD, John P	Lackawanna
LESNICK, MD, James E	Philadelphia
LESNOCK, MD, Robert G	Washington
LESSE, MD, S Michael	Northampton
LESSIG, MD, Harry J	Philadelphia
LESSIN, MD, Stuart R	Delaware
LESTER, MD, Daniel E	Washington
LESTER, MD, Mark C	Lehigh
LETO, MD, Francesco	Philadelphia
LETOCHA, MD, Charles E	York
LETWIN, MD, Lee B	Montgomery

LEUCCI, MD, Gino	Philadelphia
LEUTE, MD, Millard S	Delaware
LEVAN, MD, John B	Berks
LEVAN, MD, Melodee S	Lycoming
LEVANDOSKI JR, MD, Gerald J	Montour
LEVENBERG, MD, David	Philadelphia
LEVENDORF, MD, Melvin	Allegheny
LEVENSON, MD, Carl	Philadelphia
LEVENTHAL, Edward K	Students
LEVENTHAL, MD, Lawrence J	Philadelphia
LEVETTE, MD, Andrew R	Philadelphia
LEVEY, MD, Gerald S	Allegheny
LEVICK, MD, Leonard J	Philadelphia
LEVICK, MD, Marvin H	Allegheny
LEVICK, MD, Stanley N	Philadelphia
LEVIN, MD, Andrew J	Philadelphia
LEVIN, MD, Barry L	Philadelphia
LEVIN, MD, Daniel M	Dauphin
LEVIN, MD, Gary J	Chester
LEVIN, MD, Gene D	Bucks
LEVIN, MD, Jack M	Philadelphia
LEVIN, MD, Joseph F	Philadelphia
LEVIN, MD, Kenneth J	Allegheny
LEVIN, MD, Leonard L	Dauphin
LEVIN, MD, Mark	Philadelphia
LEVIN, MD, Michael D	Philadelphia
LEVIN, MD, Morris	Bucks
LEVIN, MD, Norman P	Philadelphia
LEVIN, MD, Richard L	Bucks
LEVIN, MD, Richard M	Lancaster
LEVIN, MD, Robert W	Philadelphia
LEVIN, MD, Ronald M	Philadelphia
LEVIN, MD, Simon	Delaware
LEVINE, MD, Alan P	Berks
LEVINE, MD, Arnold H	Philadelphia
LEVINE, MD, Arthur L	Lehigh
LEVINE, MD, Charles R	Lehigh
LEVINE, Daniel B	Allegheny
LEVINE, MD, Jacob	Westmoreland
LEVINE, MD, Jeffrey R	Philadelphia
LEVINE, MD, Macy I	Allegheny
LEVINE, MD, Mark A	Montour
LEVINE, MD, Phillip R	Allegheny
LEVINE, MD, Samuel	Philadelphia
LEVINE, MD, Sheldon R	Allegheny
LEVINSKY, MD, Walter J	Philadelphia
LEVINSON, MD, Alan K	Philadelphia
LEVINSON, MD, Bradley A	Allegheny
LEVINSON, MD, Julian P	Allegheny
LEVINSON, MD, Sander J	Lackawanna
LEVINSON, MD, William D	Westmoreland
LEVIS, MD, Michael P	Allegheny
LEVISON, MD, David J	Allegheny
LEVISON, MD, Sandra P	Philadelphia
LEVIT, MD, Edithe J	Philadelphia
LEVIT, MD, Samuel M	Philadelphia
LEVITSKY, MD, Carl M	Philadelphia
LEVITT, MD, Daniel J	Bradford
LEVITT, MD, Jerry D	Philadelphia
LEVITT, MD, Lawrence P	Lehigh
LEVY, MD, David J	Erie
LEVY, MD, Edwin J	Delaware
LEVY, MD, Frank D	Philadelphia
LEVY, MD, Howard A	Philadelphia
LEVY, MD, Jacob J	Lehigh
LEVY, MD, Jeffrey A	Cambria
LEVY, Jon A	Allegheny
LEVY, MD, Joseph	Philadelphia
LEVY, MD, Leslie J	Allegheny
LEVY, MD, Marshall S	Allegheny
LEVY, MD, Michael H	Philadelphia
LEVY, MD, Paul F	Berks
LEVY, MD, Reinhardt D	Allegheny
LEVY, MD, Richard A	Philadelphia
LEVY, MD, Richard S	Philadelphia
LEVY, MD, Sharon F	Philadelphia
LEVY, MD, William	Philadelphia
LEW, MD, Chung M	Beaver
LEWANDOWSKI, Thomas D	Allegheny
LEWBART, MD, Marvin L	Delaware
LEWIN, MD, Julian R	Allegheny
LEWIN, MD, Karl K	Allegheny
LEWIN, MD, Stanley B	Dauphin
LEWINE, MD, Yale S	Cambria
LEWINN, MD, Laurence R	Montour
LEWIS, MD, Alan E	Philadelphia
LEWIS, MD, Daniel W	Philadelphia
LEWIS, MD, Earl T	Chester
LEWIS, MD, Gregory L	Cumberland
LEWIS, MD, Henry C	Westmoreland
LEWIS, MD, Howard S	Philadelphia
LEWIS, MD, Ivor	Northumberland
LEWIS, DO, James	Delaware
LEWIS, MD, Kathryn A	Blair
LEWIS, MD, L Clifford	Chester
LEWIS, MD, Maurice J	Dauphin
LEWIS, MD, Paul L	Philadelphia
LEWIS, MD, Richard P	Allegheny
LEWIS, MD, Robert E	Allegheny
LEWIS, MD, Scott B	Chester
LEWIS, MD, Stuart H	Delaware
LEWIS, MD, Thomas J	Washington
LEWIS, MD, Victor D	Philadelphia
LEWIS, MD, William J	Delaware
LEWIS JR, MD, George C	Philadelphia
LEWIS JR, MD, Howard T	Allegheny
LEWIS JR, MD, Thomas J	Allegheny
LEWITT, MD, Michael H	Philadelphia
LEYDIG, MD, Richard A	Westmoreland
LEYENDECKER, John R	Students
LEZEK, MD, Vincent J	Allegheny
LIACHOWITZ, MD, Claire H	Philadelphia
LIANG, MD, David Y	Allegheny
LIANG, MD, Maria	Allegheny
LIANG, MD, Ping Tchang	Allegheny
LIAW, MD, Ming T	Philadelphia
LIAW, MD, Wen Haw	Philadelphia
LIBASSI, Mark J	Students
LIBERACE, MD, Ettore V	Delaware
LIBERI, MD, Alfred A	Delaware
LIBERTA, MD, Thomas R	Northampton
LIBONATI, MD, Margaret M	Philadelphia
LIBSTER, DO, Boris	Philadelphia
LIBUNAO III, MD, Jose P	Venango
LICHT, MD, Harvey M	Philadelphia
LICHTENBERG, MD, Richard A	Delaware
LICHTENSTEIN, David R	Students
LICHTENSTEIN, MD, Israel	Philadelphia
LICHTENSTEIN, MD, Stephen B	Philadelphia
LICHTER, MD, Isadore A	Allegheny
LICHTER, MD, James G	Allegheny
LIDDELL, MD, Albert G	Lycoming
LIDEN, MD, Craig B	Allegheny
LIEBEN, MD, Jan	Philadelphia
LIEBENBERG, MD, Robert E	Philadelphia
LIEBER, MD, Claude P	Philadelphia
LIEBERMAN, Bruce L	Students
LIEBERMAN, MD, Daniel	Philadelphia
LIEBERMAN, MD, Donald H	Philadelphia
LIEBERMAN, MD, Francis A	Lehigh
LIEBERMAN, MD, Frederick S	Philadelphia
LIEBERMAN, MD, George E	Philadelphia
LIEBERMAN, MD, Samuel	Philadelphia
LIEBERMAN JR, MD, Joseph A	Lehigh
LIEBLER, MD, George A	Allegheny
LIEBMAN, MD, Emil P	Philadelphia
LIEBMAN, MD, Irvin M	Bucks
LIEBMAN, MD, Ronald	Philadelphia
LIEDKE, MD, Richard D	Allegheny
LIEF, MD, Harold I	Philadelphia
LIFTON, MD, Lester J	Dauphin
LIGGETT, MD, John S	Allegheny
LIGGETT, MD, Joseph G	Allegheny
LIGHT, MD, Harry G	Northampton
LIGHT, MD, John H	Centre
LIGHT, MD, John J B	Lebanon
LIGHT, MD, Wilma C	Westmoreland
LIGHTFOOT, MD, William P	Philadelphia
LIGNELLI, MD, Gregory J	Berks
LIGUSH JR, John	Students
LIKOFF, MD, William	Philadelphia
LILIK, MD, Kenneth W	Lackawanna
LILLEY, MD, George W	Delaware
LILLI, MD, Elmo J	Monroe
LIM, MD, Dawson	Allegheny
LIM, MD, Edward T	Fayette
LIM, MD, Heng-Feng	Dauphin
LIM, MD, Lourdes T	Mercer
LIM, MD, Michael K	Lackawanna
LIM, MD, Nyok Kheng	Philadelphia
LIM, MD, Osmundo U	Delaware
LIM, MD, Rebecca Bello	Bradford
LIM, MD, Young K	Westmoreland
LIMBERAKIS, MD, Anthony J	Philadelphia
LIMBERGER, MD, William A	Chester
LIMBERT, MD, Lawrence	Montgomery
LIMCUANDO, MD, Emiliano D	Somerset
LIMKAKENG, MD, Alexander D	Mercer
LIMOGES, MD, Richard F	Philadelphia
LIN, MD, Ching H	Schuylkill
LIN, MD, Hong-Der	Allegheny
LIN, MD, Luke	Allegheny
LIN, MD, Mei Pu	Schuylkill
LIN, MD, Ming-Shek	Allegheny
LIN, MD, Paul M	Philadelphia
LIN, MD, Pu Ching	Elk/Cameron
LIN, MD, Rong-Chung	Allegheny
LIN, MD, Shiow-Bih	Allegheny
LIN, MD, Wu Jan	Elk/Cameron
LIN, MD, Zwu-Shin	Lehigh
LINCOFF, MD, William	Delaware
LINDBLAD, MD, John H	Allegheny
LINDBLAD, MD, Robert W	Philadelphia
LINDEMUTH, MD, Edmund K	Bucks
LINDENBAUM, MD, Jorge	Allegheny
LINDENFELD, MD, Arthur	Lehigh
LINDER, Lawrence S	Students
LINDER, MD, Lisa J	Delaware
LINDER, MD, Paul G	Allegheny
LINDHOLM, MD, Dale D	Lackawanna
LINDQUIST, MD, John N	Philadelphia
LINDSEY, MD, Richard L	Allegheny
LINDVIG, MD, Kirk P	Montgomery
LINE, MD, Dennis E	Cumberland
LING, MD, Charles C	Schuylkill
LINGANNA, MD, B Y	Lawrence
LINGUITI, MD, Charles	Montour
LINHART, MD, Randolph W	Allegheny
LINHART, MD, William O	Allegheny
LINN, MD, John L	Warren
LINN JR, MD, Jay G	Allegheny
LINNEMANN, MD, Roger E	Philadelphia
LINTGEN, MD, Arthur B	Montgomery
LINTGEN, MD, Charles I	Philadelphia
LINTZMEYER, MD, Emil A	Delaware
LIPANA, MD, Narcisa	Westmoreland
LIPANA, MD, Oscar N	Westmoreland
LIPAPIS, MD, Christy N	Allegheny
LIPCIUS, MD, Frank	Delaware
LIPKIN, MD, David E	Montgomery
LIPMAN, MD, Bernard L	Philadelphia
LIPMAN, MD, Rodney C	Allegheny
LIPMAN, MD, Sidney P	Erie
LIPPERT, MD, Louis C	Jefferson
LIPPMANN, MD, Michael L	Philadelphia
LIPPO, MD, Frank L	Philadelphia
LIPSCHUTZ, MD, Arthur	Philadelphia
LIPSCHUTZ, MD, Samuel S	Philadelphia
LIPSHUTZ, MD, Harold	Philadelphia
LIPSHUTZ, MD, William H	Philadelphia
LIPSITZ, MD, H David	Allegheny
LIPSIUS, MD, Edward I	Philadelphia
LIPSON, MD, Stephen D	Lycoming
LIPTON, MD, Allan	Dauphin
LIPTON, MD, Steven E	Montgomery
LIS, MD, Edward T	York
LISAN, MD, Philip	Philadelphia
LISBERGER, MD, Mark D	Delaware
LISKA, MD, John R	Westmoreland
LISKER, MD, Sheldon A	Philadelphia
LISOSKIE, Michelle D	Students
LISOWITZ, MD, Gerald M	Westmoreland
LISS, MD, Gilbert A	Chester
LISTA, MD, William A	Delaware
LISTWA, DO, Howard M	Lehigh
LITKA, MD, Paul A	Philadelphia
LITRENTA, MD, David E	York
LITT, MD, Lawrence M	Montgomery
LITTLE, MD, Dana W	Allegheny
LITTLE, MD, G Robert	Dauphin
LITTLE, MD, Robert G	Dauphin
LITTMAN, MD, Solomon I	Delaware
LITTON, MD, Jason J	Dauphin
LITTON, MD, Linda T	Dauphin
LITVIN, MD, Henry	Montgomery
LITWIN, MD, Stephen D	Bradford
LIU, MD, Jung Ching	Philadelphia
LIU, MD, Winston T	Philadelphia
LIVECCHI, MD, John T	Lackawanna
LIVELY, MD, Henry S	Bradford
LIVOLSI, MD, Philip D	Philadelphia
LIZANO, MD, Lilia I	Philadelphia
LLEWELLYN, MD, William J	Wyoming
LLINAS, MD, Alfredo J	Bradford
LLOYD, MD, David A	Allegheny
LLOYD, MD, Edgar C	Berks
LLOYD, MD, Gerald R	Erie
LLOYD, MD, Jon C	Allegheny
LOBAS, MD, David M	Allegheny
LOBES JR, MD, Louis A	Allegheny
LOBITZ, MD, Stanley A	Luzerne
LOBL, MD, Lawrence T	Allegheny
LOBUR, MD, David M	Allegheny
LOCHHEAD, MD, Harrie B	Philadelphia
LOCKE, MD, David L	Allegheny
LOCKE, MD, Harry R	Montgomery
LOCKEY III, MD, Stephen D	Lancaster
LOCKMAN, MD, Bruce E	Philadelphia
LODER, DO, Donald I	Berks
LODISE, MD, Raymond J	Philadelphia
LOEB, MD, Robert L	Erie
LOEB, MD, Roland A	Lancaster
LOEFFLER JR, MD, John G	Cumberland
LOEPER, MD, Donald J	Berks
LOEV, MD, Marvin	Bucks
LOEW, MD, Clifford G	Philadelphia
LOEWENBERG, MD, Leopold S	Philadelphia
LOFARO, MD, Salvatore A	Delaware
LOFTON, Julie A	Students
LOFTUS, MD, Joseph A	Luzerne
LOFTUS, MD, Thomas A	Philadelphia
LOFTUS, MD, Thomas M	Philadelphia
LOGAN, Anne D	Allegheny
LOGAN, MD, Kenneth M	Allegheny
LOGAN, MD, Lewis P	Clinton
LOGAN, MD, Thomas M	Philadelphia
LOGUE, MD, James G	Philadelphia
LOH, MD, Charles K	Cumberland
LOHIER, MD, Raymond	Philadelphia
LOHMANN, MD, Albert E	Berks
LOIS III, DO, John P	Allegheny
LOK, MD, Mai Pai	Schuylkill
LOKEY, Patricia A	Students
LOLLEY, MD, David M	Allegheny
LOMAX JR, MD, Walter P	Philadelphia
LOMBARD, MD, Michael F	Luzerne
LOMBARD, MD, Robert M	Lancaster
LOMBOY, MD, Norma T	Lehigh
LONDON, MD, Gladys Z	Delaware
LONDON, MD, Philip	Philadelphia
LONDON, MD, Richard L	Lehigh
LONDON, MD, W Thomas	Philadelphia
LONERGAN, MD, Robert P	Dauphin
LONG, MD, David A	Dauphin
LONG, MD, David M	Allegheny
LONG, MD, Edwin T	Allegheny
LONG, MD, Elmer C	Lehigh
LONG, Gregory S	Allegheny
LONG, MD, Joseph P	Cumberland
LONG, MD, Julian S	Luzerne
LONG, MD, Paul R	Luzerne
LONG, MD, Richard A	Washington
LONG, MD, Robert D	Union
LONG, MD, Ronald A	Westmoreland
LONG, MD, Theodore K	Lebanon
LONG JR, MD, Herbert C	Indiana
LONG JR, MD, William C	Clinton
LONG SR, MD, William L	Philadelphia
LONGABAUGH, MD, Edward E	Allegheny
LONGARINI, MD, Amilcar E	Schuylkill
LONGENBACH, MD, Eric W	Columbia
LONGENDERFER, MD, Roger L	Lancaster
LONGENECKER, MD, Benjamin E	Berks
LONGENECKER, MD, Roger N	Berks
LONGENHAGEN, MD, John B	Lehigh
LONGWELL, MD, Robert H	Lancaster
LONGWELL JR, MD, Benton E	Cambria
LONSDORF, MD, Richard G	Philadelphia
LOOKINGBILL, MD, Donald P	Dauphin
LOOMIS, MD, James W	Lackawanna
LOPATIN, MD, Mark A	Philadelphia
LOPEZ, MD, Aisa G	Philadelphia
LOPEZ, Bernard L	Students
LOPEZ, Cecilio C	Students
LOPEZ, MD, Frank	Chester
LOPEZ, MD, Frank W	Dauphin
LOPEZ, MD, Rafael H	Philadelphia
LOPEZ, MD, Rafael R	Philadelphia
LOPEZ, MD, Ubaldo P	Montour
LOPONTE, MD, Marie A	Philadelphia
LOPUSNIAK, MD, Mieczyslaw S	Delaware
LORBER, MD, Stanley H	Philadelphia
LORD, MD, Brian	Philadelphia
LORD, MD, Kenneth J	Erie
LORD, MD, William H	Berks
LORENTZ, MD, Gerald T	Franklin
LORENZ, MD, Howard	Philadelphia
LORENZ III, MD, Stephen A	Allegheny
LORENZO, MD, Frederick V	Adams
LORENZO, MD, Nicholas F	Jefferson
LORICO, MD, Abegael N	Philadelphia
LORRY, MD, Ralph W	Philadelphia
LOSASSO, MD, Dominic E	Armstrong
LOTKE, MD, Paul A	Philadelphia
LOTTICK, MD, Edward A	Luzerne
LOTZ, MD, Andrew J	Chester
LOUCKS, MD, James H	Philadelphia
LOUGHEAD JR, MD, John R	Berks
LOUGHLIN, MD, Richard R	Montgomery
LOUIS-CHARLES, MD, Roy	Philadelphia
LOUKA, MD, Mounir H	Philadelphia
LOUX, MD, Norman L	Bucks
LOVE, MD, Carol A	Philadelphia
LOVE, Karl F	Allegheny
LOVE, MD, Michael B	Philadelphia
LOVE, MD, Willard H	Dauphin
LOVECCHIO, MD, Francis A	Monroe
LOVELAND, MD, Mary W	Philadelphia
LOVELL, MD, Donald R	Blair
LOVERANES, MD, Mariano D	Erie
LOVETTE, MD, John B	Cambria
LOVRINIC, MD, Daniel F	Luzerne
LOVRINIC, MD, William S	Chester
LOW, MD, Diong O	Philadelphia
LOW, MD, Thomas H	Northampton
LOWDER JR, MD, Ralph J	Allegheny
LOWE, MD, David A	Philadelphia
LOWE, MD, Raymond E	Warren
LOWE, MD, Stephen J	Philadelphia
LOWELL, MD, Fred M	Lancaster
LOWERY, MD, Willa D	Allegheny
LOWMAN, MD, Gerald F	Northampton
LOWRY, MD, Don A	Cambria
LOWRY, MD, Donald J	Dauphin
LOWRY, MD, Louis D	Philadelphia
LOWRY, MD, R Tempest	Berks
LOWRY, DO, Susan M	Delaware
LOWY JR, MD, Alexander D	Allegheny
LOYCHIK, MD, Robert L	Blair
LOYCHIK, MD, Sandra G	Blair
LOZANO, MD, Ramon G	Allegheny
LU, MD, Milton M	Lancaster
LU, MD, Ta Shung	Bradford
LUBAHN, MD, John D	Erie
LUBBE, MD, Willem J	Lycoming
LUBECK, DO, Joseph S	Philadelphia
LUBIC, MD, Lowell G	Allegheny
LUBIN, MD, Joseph D	Philadelphia
LUBIZKA, MD, Alexandria	Philadelphia
LUBLIN, MD, Fred D	Philadelphia
LUBOW, MD, Harry	Westmoreland
LUBOWITZ, MD, Richard M	Montgomery
LUCANIK, MD, Sharon L	Philadelphia
LUCARINI, MD, James W	Philadelphia
LUCAS, MD, Irene D	Luzerne
LUCAS, MD, R Dubois	Philadelphia
LUCCA, MD, Michael	Philadelphia
LUCCHINO, MD, David B	Luzerne
LUCENA, MD, Aurora L	Delaware
LUCENA, MD, Ernesto E	Delaware
LUCENTE JR, MD, Edward R	Philadelphia
LUCHETTE, MD, Albert A	Mercer
LUCIER, MD, Alfred C	Delaware
LUCINE JR, MD, Albert A	Chester
LUDIVICO, MD, Charles L	Northampton
LUDKIEWICZ, MD, Wayne S	Beaver
LUDMER, MD, Mario	Allegheny
LUDWICK, David J	Students
LUDWIG, MD, Elizabeth N	Philadelphia
LUDWIG, MD, Jacob S	York
LUFT, MD, William C	Bradford
LUGANO, MD, Eugene M	Philadelphia
LUGUE, MD, Carmela S	Clearfield
LUGUE JR, MD, Amado B	Clearfield
LUISTRO, MD, Patria D	Philadelphia
LUKAS, MD, Raymond A	Lycoming
LUKASZCZYK, MD, Thomas A	Northampton

LUKETICH, James D	Students
LULL JR, MD, Clifford B	Jefferson
LUMB, MD, George D	Philadelphia
LUMISH, MD, Robert M	Allegheny
LUNA, MD, Fredesvinda	Clearfield
LUNA, MD, Roberto S	Clearfield
LUND, MD, Peere C	Cambria
LUNDIE, MD, William M	Westmoreland
LUNDY, MD, Barbara S	Montgomery
LUNDY, MD, Theodore	Philadelphia
LUNG, MD, Richard J	Luzerne
LUNSFORD, MD, Lawrence D	Allegheny
LUONGO JR, MD, Romeo A	Philadelphia
LUPARELLO, MD, Frank J	Allegheny
LUPARIELLO, MD, Angelo D	Allegheny
LUPIN, MD, Gordon W	Montgomery
LUPINETTI, MD, Michael F	Allegheny
LUPKAS JR, Raymond R	Students
LUPO, DO, Stephen F	Erie
LURIE, MD, Abraham A	Montgomery
LUSCH, MD, Charles J	Berks
LUSCHINSKY, MD, Walter	Schuylkill
LUSCOMBE, MD, Herbert A	Philadelphia
LUSCOMBE, MD, Herbert J	Bucks
LUSSER, MD, Martha A	Lehigh
LUSTBADER, MD, Michael L	Beaver
LUTHER, MD, Robert J	Cambria
LUTHRA, MD, Damyanti	Westmoreland
LUTHRA, MD, Manmohan	Westmoreland
LUTMAN, MD, Frank C	Philadelphia
LUTTERMOSER, MD, Gary K	Dauphin
LUTZ, MD, Harold E	Indiana
LUTZ, MD, Raymond J	Lehigh
LUTZ, MD, Ronald A	Lehigh
LUTZ JR, MD, Roland B	Montgomery
LUVIN, MD, Michael	Philadelphia
LUYCKX, Benoit A	Allegheny
LYCHAK, MD, John C	Northampton
LYET, MD, J Paul	Lancaster
LYKENS, MD, Harry D	Centre
LYLE, MD, Donald F	Philadelphia
LYNCH, MD, Christopher G	Lehigh
LYNCH, MD, J Edward	Philadelphia
LYNCH, MD, James D	Berks
LYNCH, MD, James J	Philadelphia
LYNCH, MD, James R	Westmoreland
LYNCH, MD, Robert E	Chester
LYNCH, DO, William J	Clarion
LYND JR, MD, Clifford W	York
LYNESS, MD, Samuel S	Montgomery
LYNN, MD, Charles A	Butler
LYNN, MD, Richard E	Westmoreland
LYON, MD, Edward	Lycoming
LYON, MD, William R	York
LYON-LOFTUS, MD, Diana J	Franklin
LYON-LOFTUS, MD, Gregory T	Franklin
LYONS, MD, Clifford H	Berks
LYONS, MD, Daniel C	Berks
LYONS, MD, Gary W	Erie
LYONS, MD, Lawrence L	Allegheny
LYONS, MD, Patricia J	Philadelphia
LYONS, MD, Ralph	Schuylkill
LYONS, MD, Richard C	Erie
LYONS, MD, Thomas A	Allegheny
LYONS, MD, Wilbert A	Bucks
LYONS JR, MD, John W	Philadelphia
LYTER, MD, David W	Allegheny
LYTLE, MD, Glenn H	Franklin
LYTLE, MD, Larry H	Clinton

M

MAAS, MD, Anthony E	Dauphin
MACANDREW, MD, Vincent I	Philadelphia
MACARANAS, MD, Renato R	Centre
MACCHIAROLI, Joseph A	Allegheny
MACDONALD, MD, Douglas A	Allegheny
MACDONALD, MD, George F	Allegheny
MACDONALD, MD, Robert R	Allegheny
MACDOUGALL, MD, Howard H	York
MACDOUGALL, MD, Robert D	York
MACEK, MD, Ralph C	Blair
MACFADYEN, MD, Bruce V	Philadelphia
MACHADO, Anapaula R	Students
MACHAJ, MD, Theodore S	Allegheny
MACHANIC, MD, Harmon J	Lycoming
MACHIKO, Gregory G	Students
MACHIRAJU, MD, V R	Allegheny
MACHT JR, MD, Elmer L	Philadelphia
MACKALL, MD, Samuel J	Luzerne
MACKAY, MD, Bruce R	Bradford
MACKELL, MD, James V	Philadelphia
MACKELL, MD, Thomas E	Bucks
MACKELL JR, MD, James V	Philadelphia
MACKENZIE, MD, Charles E	Warren
MACKENZIE, MD, Iain L	York
MACKENZIE, MD, Norman D	Chester
MACKEY JR, MD, James G	Montgomery
MACKIE, MD, Julius A	Philadelphia
MACKINNEY, MD, Charles C	Philadelphia
MACKLER, MD, Gerald L	Bradford
MACKRELL, MD, James J	Lackawanna
MACKRELL, MD, William P	Lackawanna
MACLACHLAN, MD, Margaret J	Allegheny
MACLACHLAN, MD, William W	Erie
MACLAREN, George A	Students
MACLAY, MD, Patricia L	Allegheny
MACLEAN, MD, Duncan S	Dauphin
MACLEOD, MD, Gordon K	Allegheny
MACMILLAN, MD, Bruce B	Allegheny
MACMORAN, MD, Jay W	Philadelphia
MACMURTRIE, MD, William J	Delaware
MACPHAIL, MD, John A	Westmoreland
MACUT, MD, S Sava	Dauphin
MACVAUGH III, MD, Horace	Philadelphia
MACY, MD, Charles T	Montgomery
MADAN-RAO, MD, Vijay	Philadelphia
MADANY, MD, Bahij H	Bucks
MADDALON, MD, Robert J	Philadelphia
MADDEN, MD, Francis P	Bucks
MADDEN, MD, James J	Montgomery
MADDEN, MD, Kevin G	Lackawanna
MADDEN, Lawrence D	Allegheny
MADDEN, Marian A	Allegheny
MADDEN, MD, Robert A	Bucks
MADDER, DO, Robert D	Beaver
MADDREY, MD, Willis C	Philadelphia
MADHAVAN, MD, Vasamtja C	Allegheny
MADIANOS, MD, Michael	Philadelphia
MADOFF, MD, Henry R	Allegheny
MADONNA, MD, Harry M	Philadelphia
MADONNA, MD, John J	Lehigh
MADOW, MD, Leo	Philadelphia
MADURA, MD, Joseph R	Mercer
MAERZ, MD, John C	Montgomery
MAFFEO, MD, Alphonse A	Lehigh
MAFFUCCI JR, MD, Victor	Bedford
MAGARGAL, MD, Helga O	Philadelphia
MAGARGAL, MD, Larry E	Philadelphia
MAGARGLE, MD, Rodney L	Dauphin
MAGBOJOS, MD, Quirico R	Franklin
MAGBOJOS, MD, Zenaida V	Franklin
MAGEE, MD, John G	Philadelphia
MAGEE, MD, Richard S	Blair
MAGGIONCALDA, MD, Joseph A	Philadelphia
MAGID, MD, Warren P	York
MAGILL, MD, Richard M	Philadelphia
MAGILL, MD, Richard M	Dauphin
MAGILL, MD, William H	Perry
MAGILNER, MD, Arthur D	Philadelphia
MAGILNER, MD, Louis	Philadelphia
MAGLEY, MD, Robert C	Cambria
MAGLEY, MD, Robert S	Cambria
MAGNANI, MD, Thomas J	Centre
MAGOVERN, MD, George J	Allegheny
MAGRAN, MD, Leonardo	Philadelphia
MAGUIRE, DO, F William	Chester
MAGUIRE, MD, Joseph I	Philadelphia
MAGUIRE, MD, Joseph I	Delaware
MAGUIRE, MD, Leo J	Delaware
MAGUIRE, MD, Randall F	Philadelphia
MAGUIRE JR, MD, Henry C	Philadelphia
MAGUIRE-LITCHMAN, MD, Maureen R	Luzerne
MAHA, MD, George E	Philadelphia
MAHA JR, Robert J	Allegheny
MAHALINGAPPA, MD, C	Westmoreland
MAHAN, MD, James C	Allegheny
MAHAN, MD, John P	Bucks
MAHBOUBI, MD, Riaz	Bucks
MAHER, MD, John C	Allegheny
MAHER, MD, Regis M	Fayette
MAHER, MD, Yvonne B	Allegheny
MAHER JR, MD, Thomas D	Allegheny
MAHMOOD, MD, Edna Z	Berks
MAHMUD, MD, Faruq	Montour
MAHON, MD, Marilyn S	Dauphin
MAHON, MD, Wilmer B	Dauphin
MAHON JR, MD, Frank B	Bradford
MAHOOD, MD, William H	Montgomery
MAHSOOB, MD, Abdul Hamed	Allegheny
MAIDA, MD, Frank V	Westmoreland
MAIER, MD, Willis P	Philadelphia
MAIGUR, MD, William S	Lackawanna
MAINGI, MD, Naresh S	Dauphin
MAINZER, MD, Francis K	Erie
MAINZER, MD, Francis S	Huntingdon
MAINZER, MD, Thomas R	Huntingdon
MAIORANA, MD, S Leroy	Berks
MAISEL, MD, Wilfred	Northampton
MAISELS, MD, M Jeffrey	Dauphin
MAISH JR, MD, George O	Northampton
MAITLAND, MD, Leah A	Adams
MAIVALD, MD, Pavel	Allegheny
MAIZEL, MD, Raoul D	Philadelphia
MAJDAN, MD, Joseph F	Philadelphia
MAJERONI, MD, Barbara A	Erie
MAJESKI, MD, Joseph T	Montour
MAJEWSKI, MD, Jerzy	Armstrong
MAJMUDAR, MD, Harshit P	Allegheny
MAJMUDAR, MD, Vasanti H	Allegheny
MAJOR, MD, David A	Philadelphia
MAKAROWSKI, MD, William S	Erie
MAKARY, MD, Adel Z	Montour
MAKDAD, MD, Ameene G	Westmoreland
MAKHDOMI, MD, A Rashid	Northampton
MAKHIJA, MD, Kailash R	Carbon
MAKLER, MD, Jacob S	Philadelphia
MAKNOON, MD, Ali A	Venango
MAKOUS, MD, Norman	Philadelphia
MAKSIMAK, MD, Martin	Montour
MAKWANA, MD, Girish N	Cambria
MALAMUT, MD, Jay M	Philadelphia
MALCOLM, MD, Donald C	Huntingdon
MALCOLM, MD, John A	Allegheny
MALCOLM JR, MD, John A	Union
MALDONADO, MD, Benjamin A	Clearfield
MALEK, MD, Mansour	Philadelphia
MALEY, MD, Edward D	Lancaster
MALEY, MD, John G	Clearfield
MALEY, MD, Richard H	Allegheny
MALHOTRA, MD, Narinder K	Allegheny
MALHOTRA, MD, Rajeshwar P	Mifflin/Juniata
MALHOTRA, MD, Shashpal	Mifflin/Juniata
MALHOTRA, MD, Vijay K	Cambria
MALICK, MD, Donald V	Schuylkill
MALICK, MD, Gerald P	Berks
MALIK, MD, Hussain G	Monroe
MALIK, MD, Khadija H	Chester
MALIK, MD, Khalid M	Armstrong
MALIK, MD, Maqsood A	Schuylkill
MALIK, MD, Mohammed A	Lehigh
MALIK, MD, Rajat P	Jefferson
MALIN, MD, Thomas H	Dauphin
MALINIAK, MD, Keith K	Dauphin
MALINOWSKI, MD, John A	Allegheny
MALISHAUCKI, MD, Mary G	Schuylkill
MALISHAUCKI, MD, Thomas J	Schuylkill
MALIT, MD, Fiorello G	Allegheny
MALIT, MD, Lee A	Montgomery
MALIT, MD, Paulita Y	Allegheny
MALIVER, MD, Leonard E	Indiana
MALJOVEC, MD, Joseph J	Erie
MALKIN, MD, Alan G	Philadelphia
MALKIN, MD, Richard L	Philadelphia
MALL, MD, Albert K	Cambria
MALLIN, MD, Richard K	Montgomery
MALLIN, MD, William S	Philadelphia
MALLINGER, MD, Michael	Allegheny
MALLINGER, MD, Samuel H	Beaver
MALLIT, MD, Melvin L	Allegheny
MALLOTT, MD, I Floyd	Allegheny
MALLOTT, MD, Stephen J	Westmoreland
MALLOY, MD, Edward L	Allegheny
MALLOY, MD, Edwin S	Lackawanna
MALLOY, MD, Terrence R	Philadelphia
MALMUD, MD, Leon S	Philadelphia
MALOLES JR, MD, Orlando Z	Delaware
MALONE, MD, Danny R	Philadelphia
MALONE, MD, William J	Venango
MALONEY, MD, Donald W	Montgomery
MALONEY, MD, Richard W	Erie
MALSCH, MD, Evamarie	Philadelphia
MALVAR, MD, Thomas Q	Lawrence
MAMBU, MD, Joseph F	Montgomery
MAMO, MD, George E	Westmoreland
MAMOURIAN, MD, Alexander C	Dauphin
MAMULA, MD, Milton	Allegheny
MANASSE, MD, Howard S	Erie
MANCALL, MD, Elliott L	Philadelphia
MANCHESTER, MD, George A	Lycoming
MANCIA, MD, Bonita M	Luzerne
MANCINO, MD, Peter J	Lawrence
MANDAL, MD, Sanat K	Philadelphia
MANDARINO, MD, Michael J	Philadelphia
MANDEL, MD, Martin M	Philadelphia
MANDEL, MD, Richard J	Philadelphia
MANDEL, MD, Samuel	Philadelphia
MANDEL, MD, Steven	Philadelphia
MANDELKORN, MD, Robert M	Allegheny
MANDELL, MD, Morton S	Philadelphia
MANDERS, MD, Ernest K	Dauphin
MANDETTA, MD, Donald F	Centre
MANDLER, MD, John I	Montgomery
MANGAN, MD, Thomas F	Montour
MANGANIELLO, MD, Charles M	Luzerne
MANGES, MD, John P	Franklin
MANGES, MD, W Bosley	Philadelphia
MANGES, MD, Willis E	Philadelphia
MANGIONE, MD, Salvatore	Chester
MANGO, MD, Albert E	Erie
MANI, MD, Shobha T	Philadelphia
MANIGLIA, MD, Angelo J	Blair
MANIGLIA, MD, Anthony J	Blair
MANIGLIA, MD, Rosario	Dauphin
MANKO, MD, Michael A	Montgomery
MANKOVICH, MD, Paul A	Westmoreland
MANLEY, MD, Charles R	Susquehanna
MANLEY, MD, Donelson R	Philadelphia
MANLEY, MD, John G	Philadelphia
MANLOVE, MD, Francis R	Philadelphia
MANN, MD, Arthur F	Montgomery
MANN, Denise L	Students
MANN, MD, Douglas G	Delaware
MANN, MD, Eric A	Erie
MANN, MD, Irving A	Delaware
MANN, MD, Lowell D	Lancaster
MANN, MD, Richard H	Lancaster
MANN, MD, Richard M	Allegheny
MANN, MD, Robert J	Montgomery
MANN JR, MD, William M	Warren
MANNING, MD, Dennis M	Fayette
MANNING, MD, Harry L	Lycoming
MANNING, MD, James A	Allegheny
MANNING, MD, Russell G	Jefferson
MANNINO, MD, Stanley C	Allegheny
MANOLIO, MD, Richard L	Erie
MANRIQUE, MD, Jose V	Luzerne
MANSELL, MD, John L	Lawrence
MANSFIELD, MD, Carl M	Philadelphia
MANSFIELD, MD, Paul F	Philadelphia
MANSTEIN, MD, Carl H	Philadelphia
MANSTEIN, MD, George	Philadelphia
MANSTEIN, Joanne L	Students
MANSTEIN, MD, Mark E	Philadelphia
MANSURE, MD, Frank T	Delaware
MANSURE, MD, Patricia R	Delaware
MANTIA, MD, August M	Allegheny
MANTICA, MD, Robert P	Beaver
MANUBAY, MD, Marcelo A	Berks
MANUEL, MD, Laureano M	Columbia
MANUS, MD, Nathan	Philadelphia
MANZ, MD, Donald J	Montgomery
MANZELLA, MD, John P	York
MANZETTI, MD, Gene W	Allegheny
MANZIONE, MD, Marc	Montgomery
MAPP, MD, Esmond M	Philadelphia
MAQUERA, MD, Andres G	Lehigh
MARASCO JR, MD, Joseph A	Allegheny
MARATTA, MD, Jan W	Allegheny
MARAVALLI, MD, Camille J	Cambria
MARBACH, MD, A Herbert	Philadelphia
MARCELLA, MD, Lawrence C	Lawrence
MARCELO, MD, Flordeliza S	Philadelphia
MARCH, MD, Herman C	Montgomery
MARCH, MD, Noreen M	Delaware
MARCHANT, MD, Deforrest W	Delaware
MARCHETTO, Barry E	Allegheny
MARCHINSKI, MD, Leonard J	Philadelphia
MARCINCIN, MD, Robert P	Northampton
MARCOLINA, MD, Susan T	Philadelphia
MARCONIS, MD, Joseph T	Schuylkill
MARCOS, MD, Cecilia S	Philadelphia
MARCUCCI, MD, James W	Allegheny
MARCUS, MD, Florence L	Allegheny
MARCUS, MD, Gary J	Beaver
MARCUS, MD, Jerome I	Berks
MARCY, MD, Joseph H	Allegheny
MARDEN, MD, Philip A	Philadelphia
MARFATIA, MD, Sudhir K	Bucks
MARFATIA, MD, Usha S	Bucks
MARGARIDA, MD, Leopoldo E	Montgomery
MARGATE, MD, Pedro R	Philadelphia
MARGIE JR, MD, Walter E	Northampton
MARGOLES, MD, Louis	Philadelphia
MARGOLIES, MD, M Price	Chester
MARGOLIES, MD, Michael	Chester
MARGOLIS, Andrew L	Students
MARGOLIS, MD, Bernard	Philadelphia
MARGOLIS, MD, Bernard M	Dauphin
MARGOLIS, MD, Harry M	Allegheny
MARGOLIS, MD, Stephen H	Philadelphia
MARGUGLIO, DO, A Eugene	Clarion
MARGULIES, MD, Milton	Delaware
MARI-MAYANS, MD, Juan B	Cambria
MARIANI, MD, Peter J	Philadelphia
MARIANI, MD, Stephen S	Lackawanna
MARIANO JR, MD, Benedicto P	Westmoreland
MARIANO JR, MD, Tomas A	Lycoming
MARIGLIO JR, MD, Joseph A	Berks
MARINARI, MD, Lawrence A	Montgomery
MARINO, MD, Daniel J	Delaware
MARINO, MD, Frederick E	Beaver
MARINO, MD, Joseph N	Lackawanna
MARINO, MD, Joseph V	Bradford
MARION, MD, Roy H	Beaver
MARIS, MD, Elizabeth P	Philadelphia
MARK, MD, George E	Philadelphia
MARK, MD, William S	Chester
MARKARIAN, MD, Michael	Susquehanna
MARKLEY, MD, Ralph	Lawrence
MARKMANN, MD, William J	Philadelphia
MARKOE, MD, Arnold M	Philadelphia
MARKOFF, MD, Joseph I	Philadelphia
MARKOPOLOS, MD, Melissa A	Philadelphia
MARKOSI JR, MD, Charles	Monroe
MARKOVIC, MD, Peter R	Philadelphia
MARKOW, MD, Harry G	Philadelphia
MARKS, DO, Burton	Lebanon
MARKS, MD, Fred S	Allegheny
MARKS, MD, Gerald	Philadelphia
MARKS, MD, Meyer A	Philadelphia
MARKS, MD, Pauline C	Allegheny
MARKS, MD, Stanley M	Allegheny
MARKS, MD, Victor J	Montour
MARKS-BRECK, MD, Sara	Philadelphia
MARKSON, MD, Victor I	Beaver
MARLIER JR, MD, Bertrand J	Allegheny
MARLING, MD, Ray	Allegheny
MARLOWE, MD, Frank I	Philadelphia
MARLOWE, Scott D	Students
MARLYS, MD, James P	Philadelphia
MARMAR, MD, Earl C	Philadelphia
MARMO, MD, Theodore	Lackawanna
MARNATTI, MD, Carl T	Allegheny
MARON, MD, John J	Montgomery
MARONE, MD, Phillip J	Philadelphia
MAROON, MD, Joseph C	Allegheny
MAROTTA, MD, Raymond J	Philadelphia
MAROUN, MD, William J	Carbon
MARQUEZ, MD, P Alfonso	Fayette
MARRANGONI, MD, Albert G	Allegheny
MARRONE, MD, Michael S	Lebanon
MARRONE, MD, Ralph T	Montgomery
MARRYSHOW, MD, Basil A	Allegheny
MARSH, MD, Robert J	Erie
MARSH, MD, William E	Westmoreland
MARSHALL, MD, David S	Schuylkill
MARSHALL, MD, E Wayne	Philadelphia
MARSHALL, MD, Helen L	Schuylkill
MARSHALL, MD, Jack H	Erie
MARSHALL, MD, Jane M	Venango
MARSHALL, MD, John E	Berks
MARSHALL, MD, John S	Beaver
MARSHALL, MD, Kenneth A	Allegheny
MARSHALL, MD, Linda R	Chester
MARSHALL, MD, William C	Allegheny
MARSHALL JR, MD, George D	Philadelphia
MARSHALL JR, MD, Matthew	Allegheny
MARTE, MD, Egon	Dauphin

MARTELLA JR, MD, Arthur	Montgomery
MARTHOUSE, MD, Stephen J	Mifflin/Juniata
MARTI-CALZAMILIA, MD, Luis F	Philadelphia
MARTIN, MD, Arthur E	Lancaster
MARTIN, MD, C Edwin	York
MARTIN, MD, Charles D	Allegheny
MARTIN, MD, Donald E	Lebanon
MARTIN, DO, Elvin L	Somerset
MARTIN, MD, Enos D	Dauphin
MARTIN, MD, Frederick H	Lehigh
MARTIN, MD, Fredric W	Allegheny
MARTIN, MD, Gerald B	Cumberland
MARTIN, MD, Horace F	Adams
MARTIN, MD, J Campbell	Columbia
MARTIN, MD, J Scott	Montour
MARTIN, MD, James S	Lancaster
MARTIN, MD, James W	Allegheny
MARTIN, MD, James W	Crawford
MARTIN, MD, John H	Philadelphia
MARTIN, MD, Lawrence F	Greene
MARTIN, MD, Linda D	Philadelphia
MARTIN, MD, Louis F	Dauphin
MARTIN, MD, Manuel T	Allegheny
MARTIN, MD, Martina M	Montgomery
MARTIN, MD, Richard A	Montour
MARTIN, MD, Richard E	Philadelphia
MARTIN, MD, Thomas G	Dauphin
MARTIN, MD, Thomas J	Montour
MARTIN JR, John A	Students
MARTIN JR, MD, John B	Washington
MARTIN JR, MD, Philip R	Monroe
MARTINA, DO, Peter A	Washington
MARTINEAU, MD, Perry C	Allegheny
MARTINEZ, MD, Augusto J	Allegheny
MARTINEZ, MD, Jess M	Washington
MARTINEZ, MD, Wendy	Philadelphia
MARTINEZ, MD, Zeferino	Berks
MARTINEZ-HERNANDEZ, MD, Antonio	Philadelphia
MARTINI, MD, Enrico T	Lancaster
MARTINI, MD, Victor S	Erie
MARTINSON, MD, Mark W	Montour
MARTONE, MD, Christine	Allegheny
MARTONE, MD, Louis H	Allegheny
MARTSOLF, MD, John	Beaver
MARTSOLF, MD, Robert H	Mercer
MARTUCCI, MD, John J	Monroe
MARTUCCI, MD, William J	Monroe
MARTYAK, DO, Gabriel G	Montour
MARTYAK, MD, Nicholas A	Luzerne
MARTYN, MD, Lois J	Philadelphia
MARTYNEC, MD, Bohdan	Bucks
MARTZ, MD, Mark N	Lehigh
MARTZLUF, MD, Douglas R	Franklin
MARVA, MD, Donald J	Philadelphia
MARVI, MD, Davoud	Lehigh
MARVIN, MD, Robert F	Delaware
MARWAHA, MD, Asha	Butler
MARWAHA, MD, Raj Kumar	Butler
MARX, Gail M	Allegheny
MARX, MD, Marvin H	Montgomery
MARYNIAK, MD, Girard M	Berks
MARZEWSKI, MD, David J	Montour
MASANKAY, MD, Manuel G	Lackawanna
MASCIOTRA, MD, Nicholas J	Cambria
MASH, MD, Michael J	Montgomery
MASLAND, MD, David S	Cumberland
MASLIN, MD, Stuart J	Philadelphia
MASLOFF, MD, Melvin L	Philadelphia
MASON, MD, Bernard A	Philadelphia
MASON, MD, Charles E	Venango
MASON, MD, Daniel	Philadelphia
MASON, MD, Howard J	Allegheny
MASS, MD, Burton	Philadelphia
MASSANISO, MD, Frank P	Philadelphia
MASSENGALE, MD, Alexander T	Berks
MASSEY, MD, Gordon J	Erie
MAST, MD, Clarence M	Wyoming
MAST, MD, Truman E	Lancaster
MASTANDREA, MD, Carl A	Allegheny
MASTERS, MD, Raymond E	Allegheny
MASTERS, MD, Ruth S	Allegheny
MASTRANGELO, MD, Michael J	Philadelphia
MASTRIAN, MD, Anthony S	Lawrence
MASTRINE, MD, Larry R	Cambria
MASTROIANNI, MD, Luigi	Philadelphia
MASTROPIETRO, MD, N Anthony	Lancaster
MATADAR, MD, Akbar G	Allegheny
MATEER, MD, Eugene H	Centre
MATHAI, MD, John	York
MATHEW, MD, Anna	Allegheny
MATHEWS, MD, Robert S	Lancaster
MATHEWS JR, MD, Neilson M	Montgomery
MATHIS, MD, James S	Centre
MATHUR, MD, Dinesh P	Cambria
MATHUR, MD, Kailash	Schuylkill
MATLIN, MD, Fredric J	Philadelphia
MATLIN, MD, Robert A	Lancaster
MATRAGRANO, MD, Andrew P	Montour
MATSKO, Jane R	Students
MATSKO, MD, Janine A	Philadelphia
MATSKO, MD, Michael E	Luzerne
MATSUMOTO, MD, Teruo	Philadelphia
MATTA, MD, Isaac I	Bradford
MATTA, MD, Shoukry	Lawrence
MATTAS, MD, Oliver E	Blair
MATTEI, MD, Frank A	Philadelphia
MATTEUCCI, MD, Barbara M	Philadelphia
MATTEUCCI, MD, Walter V	Philadelphia
MATTHEWS, MD, George R	Berks
MATTLEMAN, DO, Joel H	Lancaster
MATTLEMAN, MD, Steven J	Philadelphia
MATTSON, MD, Ronald J	Montgomery
MATULEWSKI, MD, Thomas J	Philadelphia
MATUNIS, MD, Joseph J	Perry
MATUNIS, Suzanne F	Students
MATUS, MD, Joseph P	Philadelphia
MATUS, MD, Nancy R	Northampton
MATZELLE, MD, Donald W	Franklin
MAUE, MD, Frederick R	Montour
MAUGANS, Todd A	Students
MAURER, MD, Carol N	Venango
MAURIELLO, DO, Charles A	Philadelphia
MAURIELLO II, MD, Alfred J	Chester
MAUST, MD, Paul E	Butler
MAXIN, MD, Charles W	Centre
MAXWELL, MD, Doris B	Westmoreland
MAXWELL, MD, Emilie L	Montgomery
MAXWELL, MD, Ned G	Allegheny
MAXWELL JR, MD, Robert A	Montgomery
MAY, MD, Andre R	Philadelphia
MAY, MD, John C	Lancaster
MAY, MD, Mark M	Allegheny
MAY, MD, Robert E	Philadelphia
MAYBERRY, DO, Joseph J	Lancaster
MAYDAK, DO, John H	Schuylkill
MAYER, MD, Bernard W	Montgomery
MAYER, MD, David P	Philadelphia
MAYER, MD, Eugene M	Philadelphia
MAYER, MD, Nathaniel H	Philadelphia
MAYER, MD, Robert A	Philadelphia
MAYERNIK, MD, David G	Allegheny
MAYERS JR, MD, Stanley P	Centre
MAYES, MD, Richard L	Montgomery
MAYHEW, MD, J Morgan	Westmoreland
MAYLOCK, MD, John H	Bedford
MAYO, LMD, Edith A	Delaware
MAYOCK, MD, Robert L	Philadelphia
MAYRO, MD, Julian	Philadelphia
MAYS, MD, Richard R	Lycoming
MAZAHERI, MD, Ahmed	Bucks
MAZER, MD, Howard	Philadelphia
MAZER, MD, Julius	Allegheny
MAZERO, MD, John R	Westmoreland
MAZIARZ, MD, Dennis M	Bucks
MAZUZ, MD, Meir	Berks
MAZZA, MD, Joseph L	Allegheny
MAZZA JR, MD, Patrick A	Berks
MAZZEI, MD, Joseph M	Allegheny
MAZZIOTTI, MD, Mario C	Westmoreland
MAZZOLA, MD, Robert D	Montgomery
MAZZONE, MD, Frank	Dauphin
MAZZONI, MD, Peter M	Philadelphia
MCADAMS, MD, Andrew J	Allegheny
MCAFEE, MD, Roy D	Venango
MCAFOOS, MD, J Allen	Allegheny
MCALEER, MD, David J	Delaware
MCALLISTER, MD, Helen B	Philadelphia
MCALLISTER, MD, John D	Allegheny
MCALLISTER II, John D	Allegheny
MCALOOSE, MD, Louis T	Luzerne
MCANDREW, MD, Francis J	Northampton
MCANDREW, MD, John J	Lackawanna
MCANDREW, MD, Paul C	Lackawanna
MCANDREW, MD, William	Dauphin
MCANENY, MD, John B	Cambria
MCARDLE, MD, David Q	Westmoreland
MCARDLE, MD, Gilbert C	Adams
MCARDLE, MD, M Jacquelyn	Adams
MCAULIFFE, MD, Thomas C	Philadelphia
MCAVOY, MD, William B	Allegheny
MCBETH JR, MD, Orville G	Adams
MCBRIDE, MD, James G	Northampton
MCCABE, MD, John S	Washington
MCCADDEN, MD, Joseph A	Delaware
MCCAFFERTY, MD, John P	Philadelphia
MCCAFFERTY, MD, Michael H	Allegheny
MCCAGUE, MD, James J	Allegheny
MCCAGUE, MD, Ned J	Allegheny
MCCAHAN, MD, Wesley F	Bedford
MCCAIRNS, MD, Robert G	Philadelphia
MCCALL, MD, William M	Dauphin
MCCANDLESS, MD, David P	Venango
MCCANDLESS, MD, Garrett C	Venango
MCCANDLESS, MD, Warren J	Venango
MCCANN, DO, James E	Beaver
MCCANN, MD, William D	Lancaster
MCCARRELL, MD, John K	Washington
MCCARRON, MD, Daniel J	Philadelphia
MCCARTER, MD, Samuel B	Venango
MCCARTHY, MD, Edward L	Washington
MCCARTHY JR, MD, John J	Allegheny
MCCARTNEY, MD, Ronald L	Erie
MCCAULEY, MD, Francis P	Philadelphia
MCCAULEY, MD, William C	Lycoming
MCCAUSLAND, MD, Paul J	Delaware
MCCHESNEY JR, MD, Charles T	Chester
MCCLAIN, MD, Charles B	Mifflin/Juniata
MCCLAIN JR, MD, Edward J	Allegheny
MCCLAIN JR, MD, Fred H	Huntingdon
MCCLAY, MD, Edward F	Philadelphia
MCCLELLAN, MD, Joseph R	Erie
MCCLELLAN, MD, R Michael	Delaware
MCCLELLAN, MD, William A	Allegheny
MCCLELLAND JR, MD, James H	Venango
MCCLENAHAN, MD, J Everett	Allegheny
MCCLENATHAN, MD, James E	Adams
MCCLINTIC, DO, William R	Bradford
MCCLINTOCK, MD, W Creighton	Allegheny
MCCLOSKEY, MD, David S	Philadelphia
MCCLOSKEY, MD, George A	Beaver
MCCLOSKEY, MD, Richard C	Allegheny
MCCLOSKEY, MD, Richard V	Philadelphia
MCCLOWRY, MD, James T	Allegheny
MCCLOY, MD, Merritt J	Westmoreland
MCCLUNG, MD, Larry S	Westmoreland
MCCLURE, MD, Carroll R	Chester
MCCLURE, MD, Dorothea F	Clearfield
MCCLURE, MD, Jonathan K	Beaver
MCCLURE, Thomas A	Allegheny
MCCLURE, MD, Thomas D	Westmoreland
MCCLURKEN, MD, James B	Montgomery
MCCLUSKY, MD, Robert C	Venango
MCCOLLUM, MD, George R	Allegheny
MCCOLLUM, Michael F	Students
MCCOMBS, MD, Elaine M	Montgomery
MCCOMBS, MD, Peter R	Philadelphia
MCCOMBS, MD, Ray D	Erie
MCCONAHY, MD, John G	Lawrence
MCCONNEL JR, MD, Charles S	Lehigh
MCCONNELL, MD, Edward L	Philadelphia
MCCONNELL, MD, Rebecca B	Allegheny
MCCONNELL JR, MD, David M	Warren
MCCONVILLE, MD, John H	York
MCCORD, MD, James A	Montgomery
MCCORMACK, Patricia A	Students
MCCORMICK, MD, Alexander R	Allegheny
MCCORMICK, MD, George M	Centre
MCCORMICK, MD, John L	Philadelphia
MCCORMICK, MD, John V	Montour
MCCORMICK, MD, Lee H	Allegheny
MCCORMICK, MD, Mark W	Beaver
MCCOY, Andrea C S	Students
MCCOY, MD, Orlo G	Bradford
MCCOY, MD, Robert L	Northampton
MCCOY, MD, Thomas D	Indiana
MCCOY III, MD, William H	Allegheny
MCCOY JR, MD, George W	Northampton
MCCRACKEN, MD, Stewart	Philadelphia
MCCRAE, MD, Charles R	Berks
MCCRAE, MD, Marcia G	Berks
MCCREARY III, MD, Thomas W	Beaver
MCCUNE, MD, Quay A	Warren
MCCUNE, MD, Wallace G	Philadelphia
MCCURDY, MD, Dino E P	Philadelphia
MCCURDY, MD, Layton	Philadelphia
MCCURDY, MD, Richard R	Delaware
MCCUTCHEON, MD, Charles T	Delaware
MCDANIEL JR, MD, Everett S	Philadelphia
MCDERMIT, MD, John R	Philadelphia
MCDERMOTT, MD, Robert W	Allegheny
MCDEVITT, Gordon R	Students
MCDONALD, MD, David R	Allegheny
MCDONALD, MD, Donald J	Philadelphia
MCDONALD, MD, Herbert M	Lackawanna
MCDONALD, MD, Kenneth M	Lehigh
MCDONALD, MD, Michael M	Philadelphia
MCDONALD, MD, Phillip R	Philadelphia
MCDONALD, MD, Thomas A	Montgomery
MCDONALD JR, DO, James F	Philadelphia
MCDONALD JR, MD, Robert H	Allegheny
MCDONNELL, MD, Thomas J	Lackawanna
MCDONNELL, MD, William V	Philadelphia
MCDONOUGH, MD, Gerard A	Lehigh
MCDOWELL, MD, Edward P	Indiana
MCDOWELL, MD, Mary J	Allegheny
MCELLIGOTT, MD, James B	Bradford
MCELREE, MD, James C	Mercer
MCELREE JR, MD, Frank E	Mercer
MCELROY, MD, Philip K	Delaware
MCELROY, MD, Walter D	Allegheny
MCELWAIN, MD, Guy E	Philadelphia
MCEVOY, MD, Robert F	Northampton
MCFADDEN, MD, Debra R	Allegheny
MCFADDEN, MD, Edith A	Philadelphia
MCFADDEN, MD, John F	Bucks
MCFADDEN, MD, William M	Philadelphia
MCFARLAND, MD, Malcolm D	Philadelphia
MCGANN, MD, Thomas R	Clinton
MCGARRY, MD, Thomas F	Bucks
MCGARVEY, MD, Joseph F	Bucks
MCGARVEY, MD, Richard N	Allegheny
MCGAVIC, MD, John S	Montgomery
MCGEARY, MD, Joseph D	Philadelphia
MCGEARY, MD, Lester E	Westmoreland
MCGEE, MD, Elizabeth L	Montgomery
MCGEE, MD, Michael J	York
MCGEE JR, MD, Joseph P	Delaware
MCGEEHAN, MD, John F	Lackawanna
MCGEEHAN, MD, John T	Montour
MCGEHEE, MD, Daniel	Venango
MCGEHEE, MD, Edward H	Philadelphia
MCGEORGE, MD, Francis R	Allegheny
MCGILL, MD, Herman I	Philadelphia
MCGILL, MD, Kenneth W	Luzerne
MCGINLEY, MD, George W	Lehigh
MCGINNIS, MD, Andrew W	Delaware
MCGLAUGHLIN, MD, Michael J	Adams
MCGLUMPHY, MD, Thomas H	Montgomery
MCGLYNN JR, MD, Thomas J	Dauphin
MCGONIGAL, MD, Michael P	Allegheny
MCGRANE, MD, Maria K	Luzerne
MCGRATH, MD, Edmund W	Luzerne
MCGRATH, MD, Joseph M	Dauphin
MCGRATH, DO, Robert C	Westmoreland
MCGRATH, DO, William J	Westmoreland
MCGRAW, MD, Donald J	Allegheny
MCGRAW, MD, James J	Wayne/Pike
MCGRAW, MD, Thomas E	Philadelphia
MCGRAW JR, MD, John J	Bucks
MCGREEVEY, MD, John R	Philadelphia
MCGREGOR, MD, Deborah	Philadelphia
MCGRUDER, MD, Ewart G	Philadelphia
MCGUIGAN, MD, Thomas M	Philadelphia
MCGUIRE, MD, Edward J	Lackawanna
MCGUIRE, MD, Francis E	Beaver
MCGUIRE, MD, James J	Northampton
MCGUIRE, MD, Richard J	Centre
MCHENRY, MD, D J	York
MCHENRY, John G	Students
MCHENRY, MD, Thomas	Allegheny
MCHUGH, MD, Elmer F	Allegheny
MCHUGH, MD, Joseph J	Lehigh
MCHUGH, MD, Regis W	Westmoreland
MCHUGH, MD, Richard D	Allegheny
MCILVAINE, MD, Paul W	Bucks
MCINROY, MD, Robert D	Dauphin
MCINTYRE, MD, Edward S	Lehigh
MCJUNKIN, MD, Cheryl L	Erie
MCKEATING, MD, Philip J	Allegheny
MCKEE, MD, Edward T	Delaware
MCKEE, MD, Michael B	Lancaster
MCKEE, MD, Robert E	Butler
MCKEE, MD, Roderick S	Philadelphia
MCKEE, MD, Wayne O	Somerset
MCKELVEY, MD, Mary E	Philadelphia
MCKENNA, MD, Marc W	Montgomery
MCKENNA, MD, Matthew T	Allegheny
MCKENNA, MD, Thomas J	Cambria
MCKENNA JR, MD, Ernest L	Montgomery
MCKENNEY, MD, Mark D	Philadelphia
MCKENZIE, MD, James G	Franklin
MCKENZIE, MD, Ray	Allegheny
MCKEOWN, MD, Henry G	Clinton
MCKEOWN, MD, Joseph E	Philadelphia
MCKEOWN JR, MD, John J	Philadelphia
MCKINLEY, MD, Erin A	Venango
MCKINLEY, MD, Richard G	Cambria
MCKINLEY, MD, Wayne S	Jefferson
MCKINLEY, MD, William M	Clarion
MCKINNEY, MD, Henry D	Blair
MCKINNEY, MD, William L	Berks
MCKINSTRY, MD, Robert B	Chester
MCKNIGHT, MD, Lancess	Delaware
MCLAMB, MD, James R	Crawford
MCLANE, MD, Rogers D	Centre
MCLAREN JR, MD, Harold J	Erie
MCLAUGHLIN, MD, Edward	Delaware
MCLAUGHLIN, MD, Edward D	Philadelphia
MCLAUGHLIN, MD, Frank W	Lancaster
MCLAUGHLIN, MD, George E	Philadelphia
MCLAUGHLIN, MD, James T	Allegheny
MCLAUGHLIN, MD, John J	Delaware
MCLAUGHLIN, DO, John P	Dauphin
MCLAUGHLIN, MD, Juanita S	Franklin
MCLAUGHLIN, MD, Thomas F	Schuylkill
MCLAUGHLIN, MD, Thomas W	Schuylkill
MCLAUGHLIN, MD, William B	Allegheny
MCLAUGHLIN JR, MD, Guy W	Philadelphia
MCLEAN, MD, James J	Berks
MCLELLAN JR, MD, Thomas G	Fayette
MCLEOD, MD, Roderick R	Armstrong
MCLIN, MD, Leon N	York
MCLOONE, MD, John C	Montgomery
MCMAHAN, MD, Joseph N	Washington
MCMAHON JR, MD, Joseph F	Northampton
MCMASTER, MD, Gilbert B	Washington
MCMASTER, MD, James H	Allegheny
MCMENAMIN, MD, Joseph P	Delaware
MCMILLAN, MD, Donald L	Allegheny
MCMILLAN, MD, James E	Allegheny
MCMILLAN, MD, William B	Allegheny
MCMILLEN, MD, James I	Dauphin
MCMONAGLE, MD, Carey L	Fayette
MCMULLEN, Susan N	Students
MCMURRAY, MD, Henry A	Westmoreland
MCMURRY, MD, Fred G	Montour
MCNALL, MD, Pearl G	Allegheny
MCNALLY, MD, Charles F	Philadelphia
MCNAMARA, MD, Marian F	Philadelphia
MCNAMEE SR, MD, William B	Delaware
MCNAUGHER, MD, William M	Allegheny
MCNEAL, MD, Samuel W	Lancaster
MCNEIL, MD, Peter E	Dauphin
MCNEIL-JACOBI, MD, Athole G	Philadelphia
MCNEILL, MD, Donald B	Erie
MCNEILL JR, MD, Robert J	Philadelphia
MCNELLIS, MD, Donald R	Northampton
MCNETT, MD, Dale L	Warren
MCNICHOLAS, MD, Edward M	Montgomery
MCNICHOLAS, MD, Kathleen W	Philadelphia
MCNULTY, MD, Barbara N	Allegheny
MCNUTT, MD, Frank H	Armstrong
MCPARLAND, MD, John J	Mercer
MCPEAK, MD, Vincent J	Philadelphia
MCQUADE, MD, James H	Allegheny
MCQUIGG, MD, Richard N	Allegheny
MCSTAY, MD, Louann M	Beaver
MCSTEEN, MD, Arthur J	Westmoreland
MCTAMMANY, MD, J Robert	Berks
MCVAY, MD, William J	Allegheny
MCWHIRTER, MD, William R	Mercer
MCWILLIAMS, MD, Fred D	Westmoreland
MEAD, MD, Robert M	Erie

MEADOW, DO, Philip B	Allegheny
MEADOWCROFT, MD, James A	Montgomery
MEANOR JR, MD, Harold H	Allegheny
MEARS, MD, Dana C	Allegheny
MEARS, MD, Elmer E	Bucks
MEARS, MD, Virginia G	Lancaster
MEBANE, MD, Tom S	Centre
MEBANE III, MD, Tom S	Centre
MECCA, MD, Donato D	Lackawanna
MECCA, MD, John J	Lehigh
MECHAEL, MD, Shawky F	Allegheny
MECHANICK, MD, Philip G	Philadelphia
MEDDEN, MD, Edwin J	Mckean
MEDIANO, MD, Wilfredo M	Philadelphia
MEDICH, MD, George F	Allegheny
MEDINA, MD, Amando R	Allegheny
MEDINA, MD, Jocyline L	Allegheny
MEDINA, MD, Rodrigo D	Carbon
MEDINA, MD, Roldan G	Fayette
MEDINGER, MD, Fred G	Philadelphia
MEDLEN, MD, Rudolph E	Fayette
MEDOFF, MD, Joseph	Philadelphia
MEDWAY, MD, Marc J	Montgomery
MEDWICK, DO, Denise M	Allegheny
MEDWICK, DO, Gerald R	Allegheny
MEEDER, MD, Lee D	Allegheny
MEEHAN, MD, John J	Philadelphia
MEERAN, MD, M Mohamed	Schuylkill
MEESS, MD, Mark A	Allegheny
MEGLIN, MD, Allen J	Allegheny
MEHARG JR, MD, John G	Berks
MEHDI, MD, Iftikhar J	Adams
MEHOK, MD, Ronald G	Allegheny
MEHTA, MD, Bharat K	Northampton
MEHTA, MD, Harshad	Allegheny
MEHTA, MD, Niharika D	Columbia
MEHTA, MD, Pankaj	Lycoming
MEHTA, MD, Shobha	Philadelphia
MEHTA, MD, Smita M	Philadelphia
MEHTA, MD, Sunil K	Mercer
MEHTA, MD, Tushar B	Philadelphia
MEHTA, MD, Varsha J	Butler
MEHTA, MD, Yogin P	Mifflin/Juniata
MEHTA, MD, Yogini R	Allegheny
MEIER, MD, Louis A	Montgomery
MEIKLE, MD, Charles E	Bradford
MEINDL, MD, George T	Washington
MEISNER, MD, Marvin H	Blair
MEISTER, MD, Donald G	Allegheny
MEISTER, MD, Steven G	Philadelphia
MELANI, MD, Kenneth R	Allegheny
MELDRUM, MD, Robert W	Columbia
MELLEN, MD, Arthur W	Philadelphia
MELLINGER, John C	Allegheny
MELLINGER, MD, Richard W	Lancaster
MELLON, MD, Robert	Berks
MELLON JR, MD, Lawrence J	Delaware
MELNICK, MD, Donald E	Delaware
MELNICK, MD, Joseph L	Philadelphia
MELNICOVE, MD, Sidney	Schuylkill
MELODY, MD, M Joseph	Delaware
MELOTTI, MD, Peter M	Allegheny
MELOY, MD, John H	Blair
MELOY, MD, Thomas R	Huntingdon
MELTZ, DO, Richard C	Delaware
MELTZER, MD, Alan J	Philadelphia
MELTZER, MD, David	Montgomery
MELTZER, MD, Lawrence E	Philadelphia
MELTZER, MD, Michele S	Philadelphia
MEMON, MD, Mohammad K	Westmoreland
MENA, MD, Lilia D	Montgomery
MENALDINO, MD, Stephen E	Delaware
MENAPACE JR, MD, Francis J	Montour
MENCHEY, MD, Milton J	York
MENDELL, MD, Jeffrey V	Allegheny
MENDELL, MD, Theodore H	Philadelphia
MENDELOW, MD, Harvey	Allegheny
MENDELSOHN, MD, Eugene	Berks
MENDELSON, MD, Myer	Philadelphia
MENDELSON, MD, S Robert	Allegheny
MENDELSSOHN, MD, Edwin	Philadelphia
MENEELY, MD, Alfred W	Dauphin
MENGEL, MD, Charles L	Lehigh
MENGEL, MD, Roger G	Berks
MENGES JR, MD, Job F	Berks
MENIN, MD, Richard A	Philadelphia
MENIN, MD, William	Philadelphia
MENIO, MD, John N	Luzerne
MENKOWITZ, MD, Bruce J	Montgomery
MENKOWITZ, MD, Elliot	Montgomery
MENNA, MD, Vincent J	Bucks
MENNELL, MD, John M	Philadelphia
MENNINGER III, MD, Fredrick J	Allegheny
MENON, MD, Venu G	Philadelphia
MENUT, MD, Gerard H	Philadelphia
MENZEL, MD, Paul H	Lackawanna
MENZIES JR, MD, William C	Mercer
MERCADO, MD, Modesto G	Lehigh
MERCED, MD, Jorge M	Venango
MERCHANT, MD, Ralph P	Franklin
MERCIER, MD, Edward E	Erie
MERCURIO, MD, Teresa	Berks
MERENSTEIN, MD, Joel H	Allegheny
MERING, MD, Thomas W	Greene
MERING JR, MD, James H	Allegheny
MERITZ, MD, Keith A	Philadelphia
MERKEL, MD, Lois M	Mercer
MERKIN, MD, Alvin	Philadelphia
MERKLE, MD, Larry N	Lehigh
MERKLE, MD, Ralph F	Lehigh
MERL, MD, Stuart A	Cumberland
MERLI, MD, Geno J	Philadelphia
MERLIN, MD, Albert A	Philadelphia
MERLIN, MD, Keith S	Philadelphia
MERLO, DO, Francis A	Wayne/Pike
MERMELSTEIN, MD, Alan M	Philadelphia
MERMELSTEIN, MD, Howard A	Allegheny
MERMELSTEIN, MD, Milton	Allegheny
MEROLA, MD, Joseph C	Northampton
MERRIMAN, MD, W Clair	Beaver
MERSHON, MD, Charles R	Lancaster
MERSKI, MD, Anthony T	Erie
MERSKY, MD, Martin R	Philadelphia
MERSKY, MD, Steven A	Philadelphia
MERSON, MD, Erich R	Chester
MERZI, MD, Allen J	Washington
MESAROS, MD, Michael J	Luzerne
MESERVE, MD, John P	Allegheny
MESETE, MD, A Francis	Delaware
MESHKOV, MD, Arnold B	Philadelphia
MESMER, MD, Roger E	Warren
MESROBIAN, MD, Hrair-George J	Montour
MESSENGER, MD, Jeffrey L	Philadelphia
MESSERSMITH, Ann K	Students
MESSNER, MD, Jean T	Dauphin
MESSNER, MD, Kenneth H	Lancaster
MESSORI, MD, Divo A	Philadelphia
META, MD, Louis D	Allegheny
METKUS, MD, Francis M	Bucks
METTLER, MD, Dallas E	Montgomery
METZ, MD, Walter A R	Allegheny
METZGAR, MD, Thomas I	Monroe
METZGER, MD, Charles W	Allegheny
METZGER, MD, Paul C	Lackawanna
METZGER, MD, Paul D	Lackawanna
METZGER, MD, Rose Anne	Philadelphia
MEYER, MD, Allen E	Delaware
MEYER, MD, David G	Westmoreland
MEYER, MD, Kenneth K	Bradford
MEYER, MD, Richard S	Philadelphia
MEYER JR, MD, Maurice M	Lebanon
MEYERS, MD, Allan F	Elk/Cameron
MEYERS, MD, Frederic A	Allegheny
MEYERS, MD, John L	Berks
MEYERS, MD, Karl R	Philadelphia
MEYERS, MD, Paul T	Cambria
MEYERS, MD, Robert W	Philadelphia
MEZZANOTTE, MD, John J	Philadelphia
MEZZANOTTE, MD, William S	Philadelphia
MIANO, MD, Lidia	Beaver
MIASKIEWICZ, MD, Stasia L	Allegheny
MICEK, MD, Edward W	Philadelphia
MICELI, MD, Silvio	Philadelphia
MICHAEL, MD, Donald J	Tioga
MICHAEL, MD, Dwight I	Allegheny
MICHAEL, MD, Eric J	Philadelphia
MICHAEL, MD, Joseph T	Allegheny
MICHAELS, MD, Bernard I	Allegheny
MICHAELS, MD, Mike	Montgomery
MICHAELS, MD, Milton M	Allegheny
MICHAELS, MD, Robert M	Bradford
MICHAELSON, MD, Carolyn Z	Philadelphia
MICHAELSON, MD, Robert I	Montgomery
MICHAELSON, MD, Thomas C	Chester
MICHAIL, MD, Sohair S	Philadelphia
MICHALS, MD, Timothy J	Philadelphia
MICHALSKI, John A	Students
MICHAUD, MD, Joseph E	Cambria
MICHEL, MD, Elliot M	Allegheny
MICHEL, MD, John P	Beaver
MICHELSTEIN, MD, Richard D	Luzerne
MICHEO, MD, William F	Philadelphia
MICHIE, MD, Alexander J	Monroe
MICHIE, MD, Catharine R	Monroe
MIDDLEMAN, MD, Rose R	Allegheny
MIDDLETON, MD, Donald B	Allegheny
MIDDLETON, MD, Robert J	Allegheny
MIDGETTE, MD, Andre S	Philadelphia
MIDGLEY, MD, Peter M	Franklin
MIDMORE, MD, John S	Montour
MIECKOWSKI, MD, Gregory C	Allegheny
MIELCAREK JR, MD, Leon M	Delaware
MIEWALD, MD, Bruce K	Allegheny
MIGLIORATO, MD, Jean K	Allegheny
MIGLIORE, MD, Joseph J	Lycoming
MIHELIC, MD, Nicholas E	Huntingdon
MIHOK, MD, Michael R	Allegheny
MIKAELIAN, MD, Diran O	Philadelphia
MIKAYA, MD, Martin L	Bradford
MIKELBERG, MD, Rose R	Philadelphia
MIKELONIS, MD, Robert J	Centre
MIKITA, MD, John J	Allegheny
MIKLOS, MD, Bernard G	Allegheny
MIKLOS, MD, Michael V	Allegheny
MIKNEVICH, MD, Maryann	Allegheny
MIKOWSKI, MD, I Edmund	Philadelphia
MIKULLA, MD, John M	Allegheny
MIKUTA, MD, John J	Philadelphia
MILAI JR, MD, A Samuel	Allegheny
MILANDER, MD, John H	Monroe
MILANI, MD, Frank A	Lackawanna
MILDENBERG, MD, Budd J	Montgomery
MILDER, MD, James E	Cambria
MILES, DO, G Bruce	Northampton
MILES, MD, Michael A	Berks
MILFORD, MD, Henry E	Dauphin
MILGRAM, MD, Kenneth K	Allegheny
MILHEIM, MD, Irvine G	Mercer
MILICH, MD, Zarko D	Monroe
MILICIA, MD, Anthony P	Philadelphia
MILKE, MD, Denis J	Dauphin
MILKS, MD, Carl J	Wayne/Pike
MILLAGER, Abby A	Allegheny
MILLENSON, MD, Michael M	Philadelphia
MILLER, MD, Alan M	Montgomery
MILLER, MD, Allen C	Philadelphia
MILLER, MD, Anton M	Schuylkill
MILLER, MD, Armand J	Philadelphia
MILLER, MD, Bernard J	Philadelphia
MILLER, MD, Brian A	Bucks
MILLER, MD, C Eugene	Lancaster
MILLER, MD, C Joseph	Philadelphia
MILLER, MD, Calvin E	Armstrong
MILLER, MD, Carl S	Lebanon
MILLER, MD, Charles F	Chester
MILLER, MD, Clarke T	Washington
MILLER, MD, Claude J	Lebanon
MILLER, MD, David H	Philadelphia
MILLER, MD, David H	Bucks
MILLER, MD, David L	Allegheny
MILLER, MD, David L	Clarion
MILLER, MD, David M	Delaware
MILLER, MD, David S	Huntingdon
MILLER, MD, Earl R	Lycoming
MILLER, Eydie G	Students
MILLER, MD, Felix H	Allegheny
MILLER, MD, Francine J	Philadelphia
MILLER, MD, Frank L	Montgomery
MILLER, MD, Frederick A	Allegheny
MILLER, MD, Gerald E	Lancaster
MILLER, MD, Gladys M	Philadelphia
MILLER, MD, Glenn	Philadelphia
MILLER, MD, Harry I	Allegheny
MILLER, MD, Henry N	Berks
MILLER, MD, Herbert D	Allegheny
MILLER, MD, Herman	Delaware
MILLER, MD, Howard A	Philadelphia
MILLER, MD, Howard J	Potter
MILLER, MD, Hugh M	Philadelphia
MILLER, MD, James M	Susquehanna
MILLER, MD, James R	York
MILLER, MD, Jay B	Berks
MILLER, MD, Jeffrey L	Philadelphia
MILLER, DO, Jeri L	Philadelphia
MILLER, DO, Jerome	Philadelphia
MILLER, MD, Jerome	Philadelphia
MILLER, MD, Jill A	Mifflin/Juniata
MILLER, DO, Joel P	Philadelphia
MILLER, MD, John L	Mercer
MILLER, MD, Joseph A	Lehigh
MILLER, MD, Joseph J	Franklin
MILLER, MD, Kenneth F	Allegheny
MILLER, MD, Kerry D	Lehigh
MILLER, MD, Lawrence S	Philadelphia
MILLER, MD, Lee C	Dauphin
MILLER, MD, Lee H	Bucks
MILLER, MD, Leon	Montgomery
MILLER, MD, Leonard D	Philadelphia
MILLER, MD, Matthew C	Philadelphia
MILLER, MD, Michael D	Allegheny
MILLER, MD, Morris	Philadelphia
MILLER, MD, Oliver F	Montour
MILLER, MD, Parry J	Lancaster
MILLER, MD, Ralph J	Indiana
MILLER, MD, Randolph J	Montour
MILLER, MD, Richard E	Schuylkill
MILLER, MD, Robert H	Montgomery
MILLER, MD, Roland E	Erie
MILLER, MD, Samuel G	Allegheny
MILLER, MD, Stephen J	Allegheny
MILLER, MD, Steven C	Allegheny
MILLER, MD, Thomas J	Montgomery
MILLER, MD, Thomas L	Somerset
MILLER, MD, Wallace T	Philadelphia
MILLER, MD, Warren A	Northampton
MILLER, MD, William B	Allegheny
MILLER, MD, William H	Allegheny
MILLER 3RD, MD, George W	Montgomery
MILLER II, MD, George C	Union
MILLER II, MD, Tom R	Erie
MILLER JR, MD, Clarence M	Allegheny
MILLER JR, MD, John W	Lancaster
MILLER JR, MD, William B	Dauphin
MILLIGAN, MD, Robert S	Allegheny
MILLINER, MD, David H	Delaware
MILLS, MD, John W	Indiana
MILLS, MD, M Duane	Dauphin
MILLS, MD, William L	Bucks
MILLS JR, MD, Lewis C	Philadelphia
MILON, MD, Charles F	Philadelphia
MILROTH, MD, William L	Franklin
MILSOVIC, MD, Robert C	Venango
MILSTEIN, MD, David	Philadelphia
MILSTEIN, MD, Seymour W	Delaware
MIN, MD, Henry M	Elk/Cameron
MIN, MD, Jung T	Beaver
MIN, MD, Tae C	Beaver
MINARD, MD, William D	Montgomery
MINDE, MD, Eric J	Allegheny
MINDE, MD, Norman	Allegheny
MINEHART, MD, Charles R	Berks
MINEHART, MD, John R	Philadelphia
MINEO, MD, Cyrus L	Chester
MINERVA, MD, Felicisima B	Philadelphia
MINERVA, MD, Justin G	Montgomery
MINES, MD, Samuel C	Allegheny
MINIELLY, MD, Richard W	Bradford
MINN, MD, Fredrick L	Montgomery
MINNER, MD, Roger J	Lehigh
MINNICH, MD, Philip H	York
MINNO, MD, Alexander M	Allegheny
MINO, MD, David E	Bucks
MINORA, MD, Michael A	Lackawanna
MINSEK, MD, Robert C	Lancaster
MINTEER, MD, James W	Elk/Cameron
MINTEER JR, DO, Donald W	Armstrong
MINTON, MD, Michael D	Allegheny
MINTON, MD, Russell F	Philadelphia
MINTZER, MD, David M	Philadelphia
MIR, MD, David J	Erie
MIRA, MD, Allan J	Cumberland
MIRAGLIA, MD, Richard J	Monroe
MIRANDA, MD, Cesar P	Butler
MIRANDA, MD, Jorge	Lackawanna
MIRANDA, MD, Ralph A	Westmoreland
MIRSKY, MD, Howard A	Erie
MIRSKY, MD, Robert S	Bucks
MIRZA, MD, Mohammad R	Lycoming
MISAGE, MD, John R	Allegheny
MISCHLER, MD, Forrest C	Erie
MISHALOVE, MD, R David	Delaware
MISHEL, MD, Henry S	Montgomery
MISHKIN, MD, Mark H	Lehigh
MISHRA, MD, Manorama	Greene
MISRA, MD, Hari K	Westmoreland
MISSANELLI, DO, John S	Bucks
MISTRY, MD, Meherwan J	Wayne/Pike
MITAL, MD, Mohan S	Cambria
MITAL, MD, Nirmal G	Cambria
MITCHELL, MD, Arthur B	Luzerne
MITCHELL, MD, Cheryl M	Allegheny
MITCHELL, MD, David R	Philadelphia
MITCHELL, MD, Donald D	Cambria
MITCHELL, MD, Fenton M	Allegheny
MITCHELL, MD, Harold L	Allegheny
MITCHELL, MD, Henry	Indiana
MITCHELL, MD, Howard F	Beaver
MITCHELL, MD, John	Allegheny
MITCHELL, MD, Michael J	Beaver
MITCHELL, MD, Robert M	Philadelphia
MITCHELL, MD, Thomas R	Westmoreland
MITCHELL, MD, William J	Fayette
MITCHON, MD, August J	Philadelphia
MITNICK, MD, Paul D	Berks
MITRA, MD, Atin K	Erie
MITRE, MD, Ricardo J	Allegheny
MITRO, MD, William	Allegheny
MITTELDORF, MD, Stephen E	Philadelphia
MITTERLING, MD, Robert C	Delaware
MITTICA, MD, Nicholas M	Lawrence
MITTLEMAN, Barbara B	Allegheny
MIURA, MD, Karen K	Philadelphia
MIZIN, MD, Lakshmi D J	Lackawanna
MLECKO, MD, Lawrence M	Allegheny
MOAKEH, MD, Mohamed	Crawford
MOBERG, MD, F Barrie	Lancaster
MODARRESS, MD, John	Schuylkill
MODI, MD, Jashwant B	Allegheny
MODIC, MD, Christopher W	Allegheny
MOEHS, MD, Charles J	Venango
MOERKIRK, MD, George E	Lehigh
MOFFITT, MD, Vincent J	Berks
MOFFITT JR, MD, George R	Dauphin
MOFFSES, MD, Garabed H	Philadelphia
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MOGIL, MD, Robert A	Philadelphia
MOGUL, MD, Robert	Bucks
MOHAMED-ALI, MD, Abul-Kassim	Lackawanna
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MOHAN, MD, Kannappan	Schuylkill
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MOHIUDDIN, MD, Mohammed	Philadelphia
MOHIUDDIN, MD, Mohammed A	Philadelphia
MOHLER, MD, J Harold	Lancaster
MOHR, MD, Rose M	Philadelphia
MOHYUDDIN, MD, Moiz	Monroe
MOIDEL, MD, Robert A	Montgomery
MOKRYNSKI, Gregory	Students
MOKYCHIC, MD, Walter E	Luzerne
MOLCHANY, MD, Ernest P	Butler
MOLDOFSKY, MD, Philip J	Philadelphia
MOLDOVER, MD, Jonathan R	Lehigh
MOLINA, MD, Ramon B	Monroe
MOLL, MD, Alison	York
MOLL, MD, David C	Bucks
MOLL, MD, George A	Philadelphia
MOLL, MD, Thomas B	Berks
MOLLER, MD, George A	Clinton
MOLLICK, MD, James A	Montgomery
MOLONEY, MD, Joseph D	Dauphin
MOLTHAN, MD, Lyndall	Lehigh
MOMAN JR, MD, Lawrence C	Allegheny
MONAHAN, MD, George R	Montgomery
MONARDO, MD, Alfred	Allegheny
MONASTERIO, MD, Jose R	Chester
MONCRIEF, MD, Richard D	Lancaster
MONDALA-OCBO, MD, Elisa V	Berks
MONDIK, Barbara L	Allegheny
MONDZELEWSKI, MD, James P	Allegheny
MONHEIT, MD, Richard S	Philadelphia
MONIGHETTI, MD, Robert A	Philadelphia
MONK, MD, John S	York
MONK JR, MD, John S	York
MONKOWSKI, MD, Alfred M	Bucks

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MONSOUR, MD, Roy C Westmoreland
MONSOUR, MD, Roy E Adams
MONSOUR, MD, William J Westmoreland
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MOODY, MD, Robert A Bradford
MOON, MD, Sung B Westmoreland
MOONDA, MD, Gulamhusain Mercer
MOONEY, MD, Benjamin R York
MOONEY, MD, William E Allegheny
MOORE, MD, Barry B Dauphin
MOORE, MD, Clarence E Dauphin
MOORE, MD, Daniel W Montgomery
MOORE, MD, David H Luzerne
MOORE, MD, David K Luzerne
MOORE, MD, Ernest E Butler
MOORE, MD, Frank Philadelphia
MOORE, MD, George W Lawrence
MOORE, MD, James P Armstrong
MOORE, MD, Jay R Philadelphia
MOORE, MD, John R Philadelphia
MOORE, MD, Joseph J Tioga
MOORE, MD, Leroy C Clinton
MOORE, MD, Matthew T Philadelphia
MOORE, MD, Michael F Lackawanna
MOORE, MD, Terence E Allegheny
MOORE, MD, Terence N Lancaster
MOORE JR, MD, Samuel R Philadelphia
MOORE JR EXEC, DIR, H David Allegheny
MOOREVILLE, MD, Michael Philadelphia
MORACA, MD, John I Allegheny
MORAITIS, MD, Constantine Z Allegheny
MORALES, MD, Agustin P Allegheny
MORALES, MD, Diego Philadelphia
MORALES, MD, Gladys D Northampton
MORALES, MD, Jose O Philadelphia
MORALES-PELAEZ, MD, Eileen S Philadelphia
MORAN, MD, John J Montour
MORAN, Paul E Students
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MORAN JR, MD, Theodore R Mercer
MORAN JR, MD, Thomas W Westmoreland
MORANI, MD, Alma D Philadelphia
MORANZ, MD, Joel G Delaware
MORASCO, MD, Edward R Lebanon
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MORELLI, MD, Anthony R Warren
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MORETTI, MD, James M Allegheny
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MOREY, MD, Merrill I Allegheny
MORFESIS, MD, F Andrew Delaware
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MORGAN, MD, Allan V Allegheny
MORGAN, MD, Charles W Philadelphia
MORGAN, MD, Jeffrey F Warren
MORGAN, MD, John M Delaware
MORGAN, MD, Joseph J Dauphin
MORGAN, MD, Owen K Cambria
MORGAN, MD, Paul W Chester
MORGAN, MD, Russell E Northampton
MORGAN, MD, Theodore J Allegheny
MORGAN, MD, William F Northampton
MORGAN JR, MD, James W Union
MORGAN JR, MD, Vernon W Lackawanna
MORGAN JR, MD, William R York
MORGANROTH, MD, Joel Philadelphia
MORGART, MD, Douglas R Luzerne
MORGENSTERN, MD, Jeffrey H Berks
MORGENSTERN, MD, Robert B Allegheny
MORGENSTERN, MD, Stephen A Montgomery
MORI, MD, Gino Lackawanna
MORI, MD, Hugo Lackawanna
MORINIGO-MESTRE, MD, Gladys Philadelphia
MORITZ, MD, Michael J York
MORITZ, MD, Mordekhai Lackawanna
MORK, MD, Gustave W Erie
MORLEY, MD, Robert R Delaware

MORONE, DO, Teresa M Philadelphia
MORREELS JR, MD, Charles L York
MORRELL, DO, Roger W Cambria
MORRIS, MD, Adrian J Lackawanna
MORRIS, MD, Eleanor G Somerset
MORRIS, MD, James A Delaware
MORRIS, MD, John L Erie
MORRIS, MD, Leslie E Allegheny
MORRIS, MD, Michele I Philadelphia
MORRIS, MD, Rebecca F Crawford
MORRIS, MD, Richard J Delaware
MORRIS, MD, Robert S Montgomery
MORRIS, MD, Sam E Allegheny
MORRIS, MD, Sheldon L Delaware
MORRIS, MD, Vernon R Berks
MORRIS, MD, William J Crawford
MORRIS JR, MD, Robert G Wyoming
MORRIS JR, DO, Wilson S Lebanon
MORRISON, MD, Alan N Lehigh
MORRISON, MD, Archibald Montgomery
MORRISON, MD, Bruce W Allegheny
MORRISON, MD, Carol A Philadelphia
MORRISON, MD, Donald E Dauphin
MORRISON, MD, Marjorie G Lehigh
MORRISON, MD, Samuel S Montour
MORRISON JR, MD, David P Bucks
MORRISON JR, MD, Ralph W Cambria
MORRISON SR, MD, Joseph F Luzerne
MORRISSEY, MD, Mark W Allegheny
MORRISSEY, MD, William L Philadelphia
MORRISSEY JR, MD, E James Berks
MORROCCO, MD, John D Allegheny
MORROW, MD, Bert A Berks
MORROW, MD, Charles A Allegheny
MORROW, MD, Gerald J Northampton
MORROW, MD, Herbert J Westmoreland
MORROW, MD, Robert A Lehigh
MORROW, MD, Robert E Philadelphia
MORROW, MD, Thayer K Westmoreland
MORSE, MD, Steven D Philadelphia
MORSE, MD, W Scott Allegheny
MORTEL, MD, Rodriguez Dauphin
MORTER, Gregory A Allegheny
MORTON, MD, John C Dauphin
MORTON, MD, Robert J Wayne/Pike
MORTON JR, MD, William A Chester
MOSCATO, MD, Anthony F Northampton
MOSCH, MD, George C Clearfield
MOSCH, MD, George C Potter
MOSCH, MD, Herman C Potter
MOSCOLA, MD, Ritamarie Philadelphia
MOSER, MD, Barbara E S Montour
MOSER, MD, Edward N Lycoming
MOSER, MD, John C Berks
MOSER, MD, Manny H Berks
MOSES, MD, George P Luzerne
MOSES, MD, James M Cambria
MOSES, MD, Melvin L Philadelphia
MOSES, DO, Richard E Philadelphia
MOSESSO JR, Vincent N Allegheny
MOSIENKO, MD, Keith D Washington
MOSKAL, MD, Joseph P Philadelphia
MOSKOVITZ, MD, Morry Beaver
MOSKOWITZ, MD, Barry D Allegheny
MOSLEY, MD, Mark R Allegheny
MOSS, MD, Edward R Philadelphia
MOSS, MD, N Henry Philadelphia
MOSS JR, MD, Vassar Y Allegheny
MOSSER, MD, Jeffrey F York
MOSSER, MD, Kevin H York
MOTLEY, MD, John F Montgomery
MOTRONI, MD, Alexsandra K Schuylkill
MOURY JR, MD, Nelson F Montgomery
MOUSSA, MD, Mohamad Blair
MOUSSA, MD, Samir M Allegheny
MOWAD, MD, Joseph J Montour
MOYER, MD, Dennis L Bucks
MOYER, MD, Dwight L Philadelphia
MOYER, MD, Earl S Dauphin
MOYER, MD, Glenn E Northampton
MOYER, MD, John F Allegheny
MOYER, MD, John H Cambria
MOYER, MD, John P Bucks
MOYER, MD, Paul R Bucks
MOYER, MD, Ray A Philadelphia
MOYER, MD, Stanley M Bucks
MOYER, MD, Susan M Philadelphia
MOYER, MD, Thelbert R Erie
MOYER EXEC, SEC, Mrs Nancy P Beaver
MOYERS, MD, Robert N Crawford
MOYLAN, MD, Joseph E Lackawanna
MOYLAN, MD, Robert E Lackawanna
MOYLAN III, MD, David J Chester
MOZLEY JR, MD, Paul D Philadelphia
MRAZ, MD, James E Erie
MRAZ, MD, John P Erie
MRKICH, MD, Robert Cambria
MRUK, MD, Celeste C Montgomery
MSZANOWSKI, MD, Edwin M Erie
MUCH, DO, Mandell J Delaware
MUCHLADO, MD, Felix J Allegheny
MUDRICK, MD, David L Delaware
MUELLER, MD, Scott D Dauphin
MUHLENBERG, MD, John P Berks
MUHLFELDER, MD, Warren J Blair
MUHONEN, MD, Oliver A Allegheny
MUKERJEE, MD, Manju G Luzerne
MUKHOPADHYAY, MD, Sukanta K Allegheny

MULBERGER, MD, Robert D Philadelphia
MULHATTEN, MD, Donald E Centre
MULHERN, MD, Lawrence M Allegheny
MULHOLLAND, MD, S Grant Philadelphia
MULL, MD, Joseph C Warren
MULL, MD, Thomas D Montgomery
MULLEN, MD, James L Philadelphia
MULLER, MD, Alfons J Philadelphia
MULLER, DO, Arthur J Dauphin
MULLER, MD, Gary W Philadelphia
MULLER, MD, H Arnold Dauphin
MULLER, MD, Otto F Delaware
MULLICK, MD, Jowheri J Venango
MULLIGAN, MD, James F York
MULLIGAN, MD, Margaret A Montgomery
MULLIGAN, MD, Robert L Berks
MULLIN, MD, Raymond J Bucks
MULLIN JR, MD, Edward M Lehigh
MULLIN JR, MD, Hugh J Bucks
MUMIE, MD, Lawrence E Luzerne
MUNCHAK, MD, Alexander M Lackawanna
MUNCHAK JR, MD, John Lehigh
MUNDTH, MD, Eldred D Philadelphia
MUNIR, MD, Mohammad M Northumberland
MUNIR, MD, Muhammad Schuylkill
MUNIZ, MD, Herminio Philadelphia
MUNOZ, MD, Juan T Allegheny
MUNRO, MD, Ross F Chester
MUNSON, MD, Frederick J Northampton
MUNTEANU, MD, Virgil P Lancaster
MUNVES, MD, Jonathan H Northampton
MURALIDHARAN, MD, Bhaskaran Cambria
MURCEK, MD, Martin A Westmoreland
MURCKO, Anita C Allegheny
MURDOCK, MD, Fred E Jefferson
MURDOCK, MD, Morton G Philadelphia
MURELLO, MD, David M Fayette
MURPHEY, MD, Sheila A Philadelphia
MURPHEY, MD, Stephen M Allegheny
MURPHY, MD, Charles C Allegheny
MURPHY, MD, Edith L Lycoming
MURPHY, MD, Edward J Philadelphia
MURPHY, MD, Francis J Delaware
MURPHY, MD, J Thomas Montgomery
MURPHY, MD, James A Chester
MURPHY, MD, John B Philadelphia
MURPHY, MD, John J Philadelphia
MURPHY, MD, Louis R Lackawanna
MURPHY, MD, Martin J Butler
MURPHY, MD, Mary H Delaware
MURPHY, DO, Pamela D Berks
MURPHY, MD, Richard J Philadelphia
MURPHY, MD, Thomas W Philadelphia
MURPHY, MD, Windell H A Philadelphia
MURPHY JR, MD, Arthur I Allegheny
MURR III, MD, George A Philadelphia
MURRAY, MD, Austin P Philadelphia
MURRAY, MD, Carroll A Jefferson
MURRAY, MD, John P Montgomery
MURRAY, MD, Pamela D Philadelphia
MURRAY, MD, Richard C Cambria
MURRAY, MD, Stephen R Northampton
MURRAY, MD, William M Dauphin
MURTAGH JR, MD, Frederick Philadelphia
MURTLAND, MD, Albert M Bradford
MUSA, MD, Alimad N Lehigh
MUSCALUS, DO, Robert S Montour
MUSGRAVE, MD, Ross H Allegheny
MUSKAT, MD, David I Allegheny
MUSMANNO, MD, Samuel A Allegheny
MUSSELMAN, MD, Kirk F Bradford
MUSSER, MD, Benjamin G Dauphin
MUSSER, MD, William T Union
MUSSER JR, MD, Harold E Somerset
MUSSIO, MD, John A Cambria
MUSSOLINE, DO, Joseph F Union
MUSTO, MD, Steven W Philadelphia
MUTSCHLER, Thomas A Allegheny
MUVDI, MD, B Charles Berks
MYCHAK, MD, Dennis R Northumberland
MYERS, MD, Abraham Philadelphia
MYERS, MD, Carl B Allegheny
MYERS, MD, Charles E Luzerne
MYERS, MD, David Philadelphia
MYERS, MD, Donald L Philadelphia
MYERS, MD, Eugene N Allegheny
MYERS, MD, Frederick B Luzerne
MYERS, MD, Gerald I Allegheny
MYERS, MD, Gilbert B York
MYERS, MD, Gordon D Dauphin
MYERS, MD, Martin A Montgomery
MYERS, MD, Paul R Elk/Cameron
MYERS, MD, Philip A Philadelphia
MYERS III, MD, Franklin J Dauphin
MYERS JR, MD, J Martin Philadelphia
MYSLEWSKI, MD, Walter J Westmoreland
MYSTAKAS, MD, Fotis G Lebanon

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NABATCHI, MD, Ahmad Clarion
NABATI, MD, Ismail Northampton
NABAVI, MD, Adbollah Centre
NACHLIS, MD, Allan D Allegheny
NACK, MD, Steven L Montgomery
NADAL, MD, Ramon B Bucks
NADEAU, MD, Gerald H Northampton
NADEL, MD, Marcell-Bernh Philadelphia
NADELLA, MD, Venkateswara R Mckean

NADER, MD, Charles R Westmoreland
NADER, MD, Joseph N Lehigh
NADIGA, MD, Chandrasekhara Beaver
NADKARNY, MD, Uday R Montour
NADLER, MD, Daniel J Allegheny
NADLER, MD, M Princeton Allegheny
NADWORNY, MD, Howard A Erie
NAEGELE, MD, Karl T Bradford
NAEGLE, MD, Matthew B Chester
NAEYE, MD, Richard L Dauphin
NAFZIGER, MD, John K York
NAGEL, MD, David B Lycoming
NAGLE, MD, Arlington A Berks
NAGLE, MD, Douglas B Erie
NAGLE, MD, Lawerece S Lawrence
NAGLE, MD, Richard W Erie
NAGLE, MD, Walter W Delaware
NAGLE, MD, Warren C Bradford
NAGLE JR, MD, Frank O Philadelphia
NAGPAL, MD, Naresh C Bradford
NAGY, MD, Robert Montour
NAIBERT, MD, James R Mifflin/Juniata
NAIDE, MD, David Philadelphia
NAIDE, MD, Meyer Philadelphia
NAIDOFF, MD, Michael A Philadelphia
NAIDORF, MD, Tobin S Philadelphia
NAIDU, MD, Jai P Lycoming
NAIK, MD, Sudhir D Bucks
NAIR, MD, Krishnan K Erie
NAIR, MD, V Krishnan Somerset
NAJI, MD, Ali Philadelphia
NAJI, MD, Mohammed H Lawrence
NAKHJAVAN, MD, Fred K Philadelphia
NALBANTIAN, MD, Michel S Philadelphia
NALEVANKO, MD, Albert M Lackawanna
NALLATHAMBI, MD, Helga N Butler
NALLATHAMBI, MD, Swamikkan A Butler
NAMEY, MD, John T Mercer
NANGIA, MD, Sushma R Allegheny
NANJUNDASWAMY, MD, Hunasagatta C Lawrence
NAPLES, MD, Jerry F Bucks
NAPLES, MD, Louis A Westmoreland
NAPOLEON, MD, Louis N Allegheny
NAPPI, MD, Dominic F Philadelphia
NARAYANAN, MD, Edathil K Bradford
NARDELLA JR, MD, Guy M Delaware
NARDINI, MD, Renato J Philadelphia
NARDONE, Donald T Students
NARDUCCI, MD, Anthony E Erie
NARDUZZI, MD, Joann V Allegheny
NARINE, Nalan Allegheny
NARLA, MD, Sudhir K Allegheny
NARTATEZ, MD, Pedro C Centre
NARUS, MD, Vetold T Erie
NARVAEZ, MD, Richard A Philadelphia
NARYSHKIN, MD, Sonya Philadelphia
NASADUKE, MD, Irene Bradford
NASCA, MD, Thomas J Allegheny
NASE, MD, Donald F Bucks
NASE, MD, Paul K Berks
NASE, MD, Paul M Bucks
NASEEM, MD, Mohammad Allegheny
NASH, MD, Esther J Philadelphia
NASH, MD, James D Montgomery
NASH, MD, Margaret J Philadelphia
NASO, MD, Francis Philadelphia
NASSAU, DO, Harvey B Montgomery
NASSIRI-RAHIMI, MD, Cyrus Philadelphia
NAST, MD, Max S Butler
NAST, MD, Philip R Philadelphia
NASUTI, MD, Floyd T Philadelphia
NATALI, MD, Daniel E Allegheny
NATHAN, MD, Radha Lackawanna
NATHAN, MD, Robert J Philadelphia
NATHANSON, MD, Juliet E Philadelphia
NATIVIDAD, MD, Nita C Montour
NATOLI, MD, Thomas J Montgomery
NAUGLE, MD, Ingrid E Allegheny
NAUSS, MD, Thomas J Luzerne
NAVALKOWSKY, MD, Peter J Lancaster
NAVARRO, MD, Roberto N Franklin
NAYAK, MD, Narayan Mckean
NAYAK, MD, Satish R Somerset
NAYAK, MD, Shobha Allegheny
NAYAK, MD, Tellar N Allegheny
NAZARI, MD, Ahmad Philadelphia
NAZZARO, MD, Ralph Venango
NEAGOY, MD, Daniel R Erie
NEAL, MD, Hunter S Delaware
NEAL, MD, Roland A Allegheny
NEAL JR, MD, Harry B Indiana
NEALE, MD, John M Indiana
NEALIS, MD, Henry J Montgomery
NEALON, MD, William K Allegheny
NEBEL, MD, Samuel F Franklin
NEDELJKOVIC, Srdjan S Students
NEDURIAN, MD, Gregory L Clinton
NEDURIAN, MD, Vram S Philadelphia
NEDWICH, MD, Alexander Lehigh
NEELEY, MD, Steven W Allegheny
NEFF, MD, Charles A Lebanon
NEFT, MD, Burton H Allegheny
NEGREY, MD, John N Delaware
NEGREY JR, MD, John N Delaware
NEIDHARDT, MD, Paul W Lancaster
NEIFELD, MD, Kenneth A Philadelphia
NEIFELD, MD, Lise L M Philadelphia
NEIGH, MD, John L Philadelphia

NEILSON, MD, Neilon Philadelphia
NEILSON, MD, Thomas J Allegheny
NEIMAN, MD, Lee M Allegheny
NEIMAN, MD, Wade A Philadelphia
NELLAS, MD, Constantine L Allegheny
NELSON, MD, Barry K Montgomery
NELSON, Debra Students
NELSON, MD, Diana F Philadelphia
NELSON, MD, Eleanor C Philadelphia
NELSON, MD, Guy M Philadelphia
NELSON, MD, Leonard B Philadelphia
NELSON, MD, Mortimer T Bucks
NELSON, MD, Nicholas M Dauphin
NELSON, MD, Paul B Allegheny
NELSON, MD, Philip K Lycoming
NELSON, MD, Robert D York
NELSON, MD, Theodore C Allegheny
NELSON, MD, Waldo E Philadelphia
NELSON, MD, Wenonah L Montgomery
NELSON, William H Students
NELSON JR, MD, Harry M Montgomery
NEMANI, MD, Pandharinath Washington
NEMEC, MD, John E Westmoreland
NEMEZ, MD, Albert Philadelphia
NEMEZ, MD, Jack S Philadelphia
NEMIR JR, MD, Paul Philadelphia
NEMIROFF, MD, Richard L Philadelphia
NEMIROVSKY, MD, Boris Philadelphia
NEMZOFF, MD, Sol L Montgomery
NESBITT, MD, Alexander R Armstrong
NESBITT, MD, John B Crawford
NESE, MD, Anthony J Lackawanna
NESI, MD, Daniel A Bucks
NESPOLA, MD, Anthony M Tioga
NESPOLI, MD, Anthony M Northumberland
NESTICO, MD, Pasquale F Philadelphia
NETTLETON, MD, James W Chester
NETTROUR, MD, Lewis F Allegheny
NETTROUR III, MD, W Scott Allegheny
NEUBAUER, MD, Richard Philadelphia
NEUMANN, MD, George L Lackawanna
NEUREUTER, MD, Louis J Lancaster
NEVILLE, MD, Edwin C Lackawanna
NEVULIS, MD, John J Montgomery
NEVYAS, MD, Herbert J Philadelphia
NEWBERG, MD, Aaron N Philadelphia
NEWBERG, MD, Jay A Allegheny
NEWBURY, MD, Robert O Lycoming
NEWCOMB, James A Allegheny
NEWCOMER, MD, David L Lancaster
NEWHALL, MD, Daniel L Montgomery
NEWHOUSE, MD, Joseph J Westmoreland
NEWILL, MD, William K Fayette
NEWKAM, DO, Charles R Dauphin
NEWKIRK, MD, John D Centre
NEWMAN, MD, Andrew Philadelphia
NEWMAN, MD, Benjamin E Philadelphia
NEWMAN, MD, Frank W Delaware
NEWMAN, DO, Harris Montgomery
NEWMAN, MD, Julius Montgomery
NEWMAN, MD, Leroy Philadelphia
NEWMAN, MD, William R Bedford
NEWMAN III, MD, William H Lackawanna
NEWMAN JR, MD, Clyde F Montgomery
NEWSOM, MD, John H Bucks
NEWTON, MD, Charles T Lackawanna
NEWTON, MD, E Douglas Allegheny
NEWTON, MD, Frederick C Dauphin
NEWTON, MD, Gene R Philadelphia
NEWTON, MD, Rex H Allegheny
NEY, MD, F Gregg Butler
NGEOW, MD, Yin K Franklin
NGUYEN, MD, Chau H Allegheny
NGUYEN, MD, De Allegheny
NGUYEN, MD, Ha T Delaware
NGUYEN, MD, Minh Q Northampton
NGUYEN, MD, Nghi V Allegheny
NGUYEN, MD, Phong Philadelphia
NGUYEN, MD, Thach N Philadelphia
NGUYEN, MD, Tinh-Chau Allegheny
NGUYEN, Toan T Allegheny
NGUYENPHO, MD, Hoa T Philadelphia
NIBBELINK, MD, Donald W Philadelphia
NICASSIO, MD, Anthony Allegheny
NICASTRO, MD, Gennaro C Philadelphia
NICHINI, MD, Franco M Chester
NICHOLAS, MD, Bradley E York
NICHOLAS, MD, Gary G Lehigh
NICHOLAS, MD, James L York
NICHOLAS, MD, Leslie Philadelphia
NICHOLAS JR, MD, Peter D Berks
NICHOLLS, MD, Joan E Schuylkill
NICHOLLS, MD, Richard H Schuylkill
NICHOLLS, MD, S Glenne Washington
NICHOLS, MD, Claude E Dauphin
NICHOLS, MD, David P Jefferson
NICHOLS, MD, Stephen F Allegheny
NICHOLS, MD, William R Allegheny
NICHOLSON, MD, Jesse T Philadelphia
NICHOLSON, MD, Joseph T Montgomery
NICHOLSON JR, MD, Walter J York
NICKENS, MD, Charles G Allegheny
NICKENS, MD, Oswald J Allegheny
NICKESON, MD, Robert W Allegheny
NICKLAS, MD, Donald A Chester
NICKLAS, MD, Gilbert L Clinton
NICKLES, MD, William A Franklin
NICOLAS, MD, Rudy J Centre
NICOLETTE JR, MD, Anthony J Westmoreland
NICOTERO, MD, James A Allegheny

NICY, MD, Nadija L Philadelphia
NIDO, MD, Michael P Cambria
NIEBAUM, MD, Albert H Berks
NIEDELMAN, MD, Meyer L Philadelphia
NIEGISCH, MD, Robert W Lancaster
NIEHLS, MD, Beverly J Berks
NIELAND, MD, Michael L Allegheny
NIELAND, MD, Nancy S Allegheny
NIELSEN, MD, R Craig Lycoming
NIELSEN, MD, Robert K Lebanon
NIELSON JR, MD, Robert P Warren
NIEMEYER, MD, Richard H Lancaster
NIERLE, MD, Richard H Lycoming
NIES, MD, Gerald F Washington
NIESEN, MD, Emil T Wayne/Pike
NIESENBAUM, MD, Leonard Philadelphia
NIETO, MD, Victor E Butler
NIEZGODA, MD, Paul E Luzerne
NIGBOROWICZ, MD, Ronald J Allegheny
NIJAKI, MD, Larry S Philadelphia
NIKOO, MD, Hooshang M Philadelphia
NILES, MD, Robert A Mckean
NIMOITYN, MD, Benjamin S Philadelphia
NIMOITYN, MD, Philip Philadelphia
NINO, MD, Raymond F Allegheny
NIREN, MD, Neil M Allegheny
NISENBAUM, MD, Harvey L Philadelphia
NISENBAUM, MD, Marcia R Allegheny
NISSLEY, MD, Jay M Union
NISTA, MD, Joseph A Allegheny
NITZBERG, MD, Robert S Allegheny
NIX, MD, Robert D Allegheny
NJO, MD, Soen H Montgomery
NOBEL, MD, Golda R Philadelphia
NOBEL, MD, Helen V Allegheny
NOBEL, MD, Joel J Philadelphia
NOBLE, MD, Ellenetta B Washington
NOBLE, MD, Jeyaseelan Bucks
NOBLE, MD, Paul H Philadelphia
NODEN, MD, George T Allegheny
NOE JR, MD, William L Bucks
NOLAN, Robert W Students
NOLAN, MD, Sean Allegheny
NOLAN, MD, Teresa A Allegheny
NOLAN JR, MD, John P Montgomery
NOLAN JR, MD, Thomas F Erie
NOLAND, MD, Robert B Allegheny
NOLL, MD, Ross N Philadelphia
NOLLER, MD, William E Lancaster
NOONE, MD, James P Bradford
NOONE, MD, R Barrett Philadelphia
NOORBAKHSH, MD, Hossein Allegheny
NORATO, MD, Joseph F Dauphin
NORD, MD, Roland E Lawrence
NORDBERG, MD, Joanne E Philadelphia
NORDENBERG, MD, Aaron Dauphin
NORK, MD, Edward P Luzerne
NORMINGTON II, MD, Ernest Y Lehigh
NORRIS, MD, Charles M Philadelphia
NORRIS, MD, David C Allegheny
NORRIS, MD, Robert F Philadelphia
NORTH, MD, Leon L Montgomery
NORTHROP, MD, Herbert L Montgomery
NORTHRUP, MD, Bruce E Philadelphia
NOSHENY, MD, Stanley Z Philadelphia
NOTARI, MD, Edward J Lackawanna
NOTARO, MD, John Beaver
NOTHMANN, MD, Bruce J Allegheny
NOTZ, MD, Robert G Montour
NOUMOFF, MD, Joel S Philadelphia
NOURIAN, MD, Ali A Lackawanna
NOVAK, MD, Joseph Allegheny
NOVAK, MD, Joseph F Allegheny
NOVAKOVIC, Rachel L Allegheny
NOVEMBER, MD, Stephen R Lackawanna
NOVESKE, MD, F Gregory Bradford
NOVINGER, MD, Quentin T Luzerne
NOVOGRADAC, MD, William E Allegheny
NOWACKI, MD, Stanley M Montgomery
NOWOSLAWSKI, MD, Joseph F Philadelphia
NSEIR, MD, Nawaf I Westmoreland
NTOSO, MD, May-Ange Philadelphia
NUCUM, MD, Afrodisio N Lebanon
NUGENT, MD, Fred B Berks
NULL, MD, Harry M Allegheny
NULLMAN, MD, Andrew E Philadelphia
NUNEZ, MD, Hermes Allegheny
NUNGESSER, MD, Raymond F Columbia
NUNNA, MD, Nagabhushanam Butler
NUNNA, MD, Sitalakshmi C Butler
NURBHAI, MD, Murtaza E Potter
NUSBAUM, MD, Moreye Philadelphia
NUSCHKE, MD, John D Bucks
NUSSBAUM, MD, Allen S York
NUSSBAUM, MD, Arthur J Allegheny
NUSSBAUM, MD, Joseph Philadelphia
NUSSBAUM, MD, Steven J Delaware
NUTT, MD, Richard L Montgomery
NUTT III, MD, James N Montgomery
NUTTER, MD, David E Lancaster
NYPAVER, Annette L Students
NZERIBE-UDOM, MD, Rita C Allegheny

O

OAKEY JR, MD, Richard S Delaware
OAKS, MD, Timothy E Dauphin
OAKS JR, MD, Wilbur W Philadelphia
OBENRADER, MD, Mark F Montgomery
OBER, MD, Henry E Westmoreland
OBERKIRCHER, MD, Oscar R Montour

OBERMESSER, MD, Christine M Philadelphia
OBLEY, MD, David L Allegheny
OBOYLE, MD, James P Lackawanna
OBOYLE, MD, Tomas A Lackawanna
OBRIEN, MD, James J Montgomery
OBRIEN, MD, Joseph J Lackawanna
OBRIEN, MD, Patrick M Philadelphia
OBRIEN, MD, Robert G Allegheny
OBRIEN, MD, William R Philadelphia
OBRIEN III, MD, Frank D Montour
OCAMPO, MD, Renato G Mckean
OCHENRIDER, MD, Paul D York
OCHOA, MD, E Ricardo Allegheny
OCHOCO-CAVANAUGH, MD, Lillian A Allegheny
OCKENHOUSE, MD, Ingrid F Philadelphia
OCONNELL, MD, Brent J Dauphin
OCONNELL, MD, C Leonard Greene
OCONNELL, MD, Fred H Philadelphia
OCONNELL, MD, James R Delaware
OCONNELL, MD, Rose R Philadelphia
OCONNOR, MD, John P Allegheny
OCONNOR, MD, John V Venango
OCONNOR, MD, Mary K Allegheny
OCONNOR, MD, Maureen E Philadelphia
OCONNOR, MD, Michael J Philadelphia
OCONNOR, Susan E Allegheny
OCONNOR, MD, Thomas W Lancaster
OCONNOR, MD, William F Beaver
OCONNOR JR, MD, James J Lackawanna
OCONOR JR, MD, Gregory T Lancaster
ODABASHIAN, MD, Arthur Delaware
ODDI, MD, Frederick J Allegheny
ODELL, MD, Sharon M Philadelphia
ODIM, MD, Usim Allegheny
ODONNELL, MD, Christine S Philadelphia
ODONNELL, MD, George J Luzerne
ODONNELL, MD, John H Allegheny
ODONNELL, MD, Walter F Allegheny
OEHRLE, MD, John S Allegheny
OELS, MD, Helen C Montgomery
OESTERLING JR, MD, Everett F Allegheny
OFALLON, MD, Denis J Allegheny
OFFNER, MD, Theodore W Philadelphia
OH, MD, Chang W Lebanon
OH, MD, Daniel S B Bucks
OH, MD, Jang K Philadelphia
OH, MD, Kook S Allegheny
OH, MD, Sung K Philadelphia
OH, MD, Yong W Luzerne
OHANISSIAN, MD, Hanrick G Delaware
OHARA, MD, Albert E Philadelphia
OHARA, MD, Kevin R Allegheny
OHARA-MATLACK, MD, Eileen Philadelphia
OHL, MD, Bettina M G Adams
OHLSON, MD, Guy E Dauphin
OJEDA, MD, Virginia L Philadelphia
OKAGAWA, MD, Rick Philadelphia
OKEEFE, MD, James F Allegheny
OKEEFE, MD, John J Philadelphia
OKEN, MD, Donald Philadelphia
OKICKI, MD, Letitia A Philadelphia
OKIN, MD, E Michael Philadelphia
OKOBI, MD, Anthony N Allegheny
OKUNSKI, MD, Walter J Lehigh
OLAH, MD, George W Allegheny
OLEAGA, MD, Juan A Philadelphia
OLEAR, DO, Mary S York
OLEARCHYK, MD, Andrew S Philadelphia
OLENGINSKI, MD, Thomas P Montour
OLEWILER JR, MD, H Newton Northampton
OLIM, MD, Dave B Montgomery
OLIN, DO, Jeffrey W Allegheny
OLIN, MD, Stephen T Lancaster
OLINSKY, MD, Stuart M Lycoming
OLIVER, MD, John G Northampton
OLIVER, MD, Orlando P Westmoreland
OLIVER JR, MD, Thomas K Allegheny
OLIVERIO, MD, Anthony J Fayette
OLIVES, MD, Manuel Dauphin
OLIVIERI, Suzanne P Students
OLKEN, MD, Mark D Philadelphia
OLLER, MD, Samuel Montgomery
OLNEY, MD, Franklin B Centre
OLSAKOVSKY, Leslie A Allegheny
OLSHAN, MD, Arthur R Philadelphia
OLSHEFSKI, Randal S Allegheny
OLSHEMSKI, MD, Frank C Luzerne
OLSON, MD, Dennis A Mckean
OLSON, MD, Emil W Montgomery
OLSON, MD, Janne R York
OLSON, MD, Mary K Allegheny
OLSON, MD, Ronald A Luzerne
OMALLEY, MD, Donald F Allegheny
OMALLEY, MD, Joseph F Montgomery
OMALLEY, MD, Kevin B Philadelphia
OMANA, MD, Jess E Bucks
ONEAL JR, MD, Alexander H Montgomery
ONEIL, DO, Robert J Allegheny
ONEILL, Daniel K Students
ONEILL, MD, Hugh Philadelphia
ONEILL, DO, James P Lancaster
ONEILL, MD, John J Delaware
ONESTI, MD, Gaddo Bucks
ONG, MD, Bienvenido S Lawrence
ONG, MD, George P Cumberland
ONG, MD, Jimmy J Allegheny
ONIFER, MD, Theodore M Montgomery

ONQUE, MD, Gloria C Allegheny
OPALACK, DO, Cheryl A Montgomery
OPASS, MD, Edward S Philadelphia
OPIDA, MD, Ciceron L Blair
OPIDA, MD, Marina Blair
OPLINGER, MD, Arthur F Berks
ORA, MD, Carmen S Philadelphia
ORAM, MD, Alan J Columbia
ORAM, MD, Melvin Lackawanna
ORANGE, MD, Paul D Franklin
ORDENTLICH, MD, Elena Philadelphia
ORDER, MD, Albert A Philadelphia
ORDINARIO JR, MD, Vicente R Crawford
ORDIWAY, MD, M Vernon Elk/Cameron
ORDWAY JR, MD, Eugene E Lehigh
ORIE, MD, John R Allegheny
ORKIN, MD, Fredrick K Philadelphia
ORLANDO, MD, Joseph D Luzerne
ORLANDO, MD, Salvatore J Allegheny
ORLIDGE, MD, Arthur E Somerset
ORMAN, MD, Jack M Philadelphia
ORMAN, MD, Steven K Dauphin
ORNE, MD, Martin T Philadelphia
OROURKE, MD, John N Montour
OROURKE, MD, Terence L Montour
ORPHANIDES, MD, Timothy Philadelphia
ORQUIZA, MD, Clodualdo S Berks
ORR, MD, Donald P Allegheny
ORR, MD, Paul L Lehigh
ORR, MD, Sidney H Philadelphia
ORR JR, MD, Ross M Northampton
ORRINGER, MD, David Allegheny
ORRIS, MD, Donald J Jefferson
ORSI, MD, James M Northampton
ORSINI, MD, Michael A Beaver
ORTLEY, DO, Glenn R Delaware
ORVIS, MD, Harold H Chester
OSBORN, MD, Hayler H Montgomery
OSBORN, MD, Ian C Centre
OSBORNE, MD, David P Mckean
OSBORNE, John A Students
OSCAR, MD, Alvin D Philadelphia
OSCHELL, MD, William J Philadelphia
OSCHWALD, MD, Charles J Cambria
OSGOOD, MD, Carroll P Blair
OSHEKA, MD, William Allegheny
OSIAL JR, MD, Thaddeus A Allegheny
OSIAS, MD, Marc B Montgomery
OSKIN, MD, Hilbert E Westmoreland
OSLICK, MD, Theodore Philadelphia
OSMICK, MD, Mary J Philadelphia
OSMOND, MD, Leslie H Allegheny
OSOFSKY, MD, Murray V Allegheny
OSORIO, MD, Emmanuel P Philadelphia
OSTDAHL, MD, Roger H Dauphin
OSTERHOLM, MD, Jewell L Philadelphia
OSTFELD, MD, David A Northampton
OSTMAN, MD, Zenaida E Dauphin
OSTROWSKI, DO, Charles A Elk/Cameron
OSTRUM, MD, Bernard J Philadelphia
OTOOLE, MD, James D Allegheny
OTOOLE, MD, Thomas F Philadelphia
OTT, MD, Gary Y Philadelphia
OTTENBERG, MD, Donald J Philadelphia
OU, MD, Kuang-Yu Allegheny
OUANO, MD, Romeo C Luzerne
OUELLETTE, Daniel R Allegheny
OUTLAND, MD, Tom Dauphin
OVERBECK, MD, Michael D Montgomery
OVERFIELD, MD, Edward M Erie
OVERLY, MD, Wylie L Westmoreland
OVITZ, MD, Morris Lehigh
OWCZYKOWSKY, MD, Bernard J Armstrong
OWEIDA, MD, Nizar N Westmoreland
OWEN, MD, Barbara J Montgomery
OWENS, MD, David E Luzerne
OWENS, MD, E Reese Allegheny
OWENS, DO, Edward J Crawford
OWENS, MD, John D York
OWENS, MD, Thomas A Cambria
OYESIKU, MD, Nelson M Philadelphia
OZ, Mehmet C Students

P

PACANOWSKI, MD, John P Bradford
PACEK, MD, Robert F Armstrong
PACHO, MD, Arelyne B Bucks
PACHTMAN, MD, Isadore Allegheny
PACIFICO, MD, Ronald L Allegheny
PACIOTTI, MD, Samuel M Monroe
PACIULLI, MD, Raffaele Berks
PACK, MD, Winifred P Philadelphia
PACKMAN, MD, Barry E Philadelphia
PACLISANU, MD, Zeno G Bucks
PACURARIU, MD, Radu I Luzerne
PADALINO, MD, Michael J Venango
PADAYHAG, MD, Matias M Berks
PADEN, MD, Drue R Luzerne
PADGET, MD, Edward S Philadelphia
PADILLA, MD, Jaime S Montgomery
PADIN, MD, Frederico A Venango
PADIYAR, MD, Ramdas B Berks
PADOLINA, MD, Ruby M Philadelphia
PADUA-DEOCERA, MD, Zaida P Bucks
PADULA, MD, Anthony M Philadelphia
PAE, MD, Dong W Westmoreland
PAE, MD, Walter E Dauphin
PAEZ, MD, Eduardo J Philadelphia

PAGANA, MD, John P	Northumberland
PAGANA, MD, Timothy J	Lycoming
PAGE, Dean A	Allegheny
PAGE, MD, Michael J	Dauphin
PAGE, MD, Robert B	Dauphin
PAGE JR, MD, Edwin H	Beaver
PAGNANELLI, MD, David Michael	Montgomery
PAGNIELLO, MD, Lucia	Crawford
PAI, MD, K Gopalkrishna	Allegheny
PALANDJIAN, MD, Khatchadour B	Lackawanna
PALANISAMY, MD, Subramaniam	Allegheny
PALANT, MD, Marina B	Philadelphia
PALAO, MD, Manuel C	Northampton
PALATIANOS, MD, George M	Philadelphia
PALATKA, MD, Andrew A	Lawrence
PALEPU, MD, Showri	Allegheny
PALIN, MD, William E	Bedford
PALKOVITZ, MD, Harry P	Allegheny
PALKOVITZ, MD, Joseph	Allegheny
PALLADINO, MD, Diane P	Philadelphia
PALLEN, MD, Daniel	Lancaster
PALMER, MD, Arthur H	Allegheny
PALMER, MD, Clarkson T	Philadelphia
PALMER, MD, Craig M	Philadelphia
PALMER, MD, Frank C	Indiana
PALMER, MD, Michael H	Franklin
PALMER, MD, U Grant	Northampton
PALMER, MD, William D	Allegheny
PALMER JR, MD, Dale H	Centre
PALMER JR, MD, William E	Cambria
PALUMBO, MD, John A	Lancaster
PALUS, MD, Bernard R	Allegheny
PALUSO, MD, Eugene F	Washington
PALUSO, MD, John R	Washington
PAN, MD, Edward L	Berks
PANAHANDEH, MD, Abolhassan	Allegheny
PANARO, MD, Rudolph J	Montgomery
PANAYOTOVA, MD, Maria L	Northampton
PANCHAL, MD, Pravin D	Allegheny
PANCOAST, MD, Stephen J	Lackawanna
PANDELIDIS, MD, Pandelis K	York
PANDIT, MD, Devayani I	Allegheny
PANDIT, MD, Indravadan N	Allegheny
PANDOLFI, MD, Frank J	Philadelphia
PANE, MD, Carmela R	Philadelphia
PANEBIANCO, MD, Antonio C	Lehigh
PANEK, MD, Bernard S	Cambria
PANETTIERI JR, MD, Reynold A	Philadelphia
PANICCO, DO, Richard J	Washington
PANIKKAR, MD, Ananda K	Columbia
PANITCH, MD, Deborah	Philadelphia
PANNOCCHIA, MD, Luis C	Delaware
PANTALONE, MD, Albert	Beaver
PANTALONE, MD, Angelo L	Allegheny
PANTALONE, MD, Frank A	Westmoreland
PANTINO, MD, Thomas M	Allegheny
PANZER, MD, Glenn M	Luzerne
PANZER, MD, Herman M	Montgomery
PAOLINI, MD, Mauro J	Berks
PAPADOPOULOS, Patricia P	Students
PAPAS, MD, Spiro N	Allegheny
PAPAZIAN, MD, Ara	Allegheny
PAPOLA, MD, Gino G	Delaware
PAPPANO JR, MD, Joseph E	Montgomery
PAPPAS, MD, Charles E	Philadelphia
PAPPAS, MD, Michael T	Allegheny
PARABOSCHI, Charles F	Allegheny
PARADOWSKI, MD, Frank W	Philadelphia
PARAGAS SR, MD, Lamberto S	Centre
PARAMESWARAN, MD, R	Philadelphia
PARANDHAM, MD, Koduri	Allegheny
PARANICAS, MD, Jamie D	Lehigh
PARANJPE, MD, Mohan K	Allegheny
PARCINSKI, DO, Richard E	Cambria
PARDINE, MD, Marilyn T	Wayne/Pike
PARENT JR, MD, Fernand N	Washington
PARENTE, MD, Romulo Q	Blair
PARENTI, MD, Dennis L	Northampton
PARENTI, MD, John M	Montour
PARESO, MD, James D	Washington
PARIKH, MD, Kiran J	Allegheny
PARIKH, MD, Mukul L	Dauphin
PARIKH, MD, Naresh	Lackawanna
PARIKH, MD, Neelima M	Dauphin
PARIKH, MD, Shirish N	Berks
PARIS, MD, Mark F	Blair
PARISH, MD, Lawrence C	Philadelphia
PARISI, MD, Erika F	Delaware
PARK, MD, Boyd N	Butler
PARK, MD, Byung S	Westmoreland
PARK, MD, Chan D	Allegheny
PARK, MD, Chan H	Philadelphia
PARK, MD, Chong H	Philadelphia
PARK, MD, Chong S	Erie
PARK, MD, Eugene	Allegheny
PARK, MD, Guy K	Philadelphia
PARK, MD, Hee-Ok	Philadelphia
PARK, MD, Hong S	Cumberland
PARK, MD, Hyung K	Philadelphia
PARK, MD, Joon O	Beaver
PARK, MD, Joseph M	Indiana
PARK, MD, Min H	Fayette
PARK, MD, Nae H	Dauphin
PARK, MD, Nancy H	Allegheny
PARK, MD, Neil I H	Cambria
PARK, MD, Pum K	Delaware
PARK, MD, Sang B	Allegheny
PARK, MD, Sung H	Schuylkill
PARK, MD, Thomas E	Fayette
PARK, MD, Young Won	Lycoming
PARKER, MD, Albert F	Chester
PARKER, MD, Albert G	Allegheny
PARKER, MD, Andrew J	Mifflin/Juniata
PARKER, MD, Anne V	Philadelphia
PARKER, MD, Artist L	Allegheny
PARKER, MD, Eleanor K	Chester
PARKER, DO, Frank	Clinton
PARKER, MD, Frederick L	Philadelphia
PARKER, Gerald B	Students
PARKER, MD, Janet A	Philadelphia
PARKER, MD, John S	Westmoreland
PARKER II, MD, Harold G	Philadelphia
PARKER JR, MD, James H	Berks
PARKS, MD, Donald B	Philadelphia
PARKS, DO, Joseph L	Indiana
PARKS JR, MD, Lytle R	Centre
PARLAVECCHIO, MD, Dennis S	Jefferson
PARLEE, MD, Donald E	Bucks
PARLIMENT, MD, Joel W	Lancaster
PARNES, MD, Herbert M	Dauphin
PARONISH, MD, William J	Cambria
PARR, MD, Grant V S	Philadelphia
PARR, MD, Justin L	Philadelphia
PARRILLO, MD, Douglas W	Lackawanna
PARRISH, Beth	Students
PARRY, MD, Carolyn E	Philadelphia
PARRY, MD, H Frazer	Philadelphia
PARRY, MD, John S	Mifflin/Juniata
PARRY, MD, Peter V	Delaware
PARRY, MD, Rhinard D	Northampton
PARSIA, MD, Keykhoskow S	Delaware
PARSICK, MD, Daniel P	Lackawanna
PARSONS, MD, Frederick A	Allegheny
PARSONS, MD, John A	Allegheny
PARSONS, MD, William H	Erie
PARSONS EXEC, SEC, Robert R	Lehigh
PARUCHURI, MD, Sra	Mercer
PARULIS, MD, Albert C	Beaver
PARVA, MD, Ghasem	Allegheny
PASCAL, MD, Harold J	Monroe
PASCAL, MD, Joseph	Lehigh
PASCAL, MD, Robert R	Philadelphia
PASCUA, MD, Alexander V	Beaver
PASCUAL, MD, Generoso S	Allegheny
PASCUCCI, MD, Stephen E	Lackawanna
PASDAR, MD, Homayoon	Philadelphia
PASHMAN, MD, David R	Philadelphia
PASKIN, MD, David L	Philadelphia
PASQUALE, MD, Michael J	Dauphin
PASQUARIELLO, MD, Patrick S	Philadelphia
PASSERO, MD, Frank C	Delaware
PASTO, MD, Matthew E	Philadelphia
PASTOR, MD, James A	Lebanon
PASTOR, MD, Larry H	Philadelphia
PATADIA, MD, Chandrakant	Berks
PATAKI, MD, Richard S	Washington
PATALINGHUG JR, MD, Pascual N	Franklin
PATANKAR, MD, Kalpana U	Chester
PATEL, MD, Aneel N	Warren
PATEL, MD, Bakulesh D	Montour
PATEL, MD, Bhupendra R	Lackawanna
PATEL, MD, Bipinchandra M	Lackawanna
PATEL, MD, Harshad K	Philadelphia
PATEL, MD, Harshad R	Lycoming
PATEL, MD, Harshadkumar B	Lancaster
PATEL, MD, Jagdish D	Cambria
PATEL, MD, Jay C	Philadelphia
PATEL, MD, Jayantilal R	Bucks
PATEL, MD, Jivanlal M	Clarion
PATEL, MD, Kantilal C	Erie
PATEL, MD, Manojkumar R	Beaver
PATEL, MD, Manubhai R	Philadelphia
PATEL, MD, Mayur	Butler
PATEL, MD, Minaxi G	Allegheny
PATEL, MD, Mohan M	Westmoreland
PATEL, MD, Mukesh A	Delaware
PATEL, MD, Natvarbhai	Montgomery
PATEL, MD, Purshottam N	Northumberland
PATEL, MD, Ramesh C	Lackawanna
PATEL, MD, Sanjay D	Montgomery
PATEL, MD, Satish D	Luzerne
PATEL, MD, Shashikant B	Dauphin
PATEL, MD, Surendra R	Lawrence
PATEL, MD, Vinod M	Erie
PATERNITI, MD, Samuel F	Lebanon
PATERSON, MD, William D	Philadelphia
PATHAK, MD, Rajani K	Jefferson
PATHEJA, MD, Jotinder K	Westmoreland
PATHROFF, MD, Robert	Montgomery
PATNAIK, MD, Ramprasad	Philadelphia
PATRICIO, MD, Alejandro M	Fayette
PATRICK, MD, David B	Beaver
PATRICK, MD, David R	Beaver
PATRICK, MD, Gregory B	Allegheny
PATRICK, MD, Michael A	Northampton
PATRICK, MD, Nicholas E	Lackawanna
PATRICK, MD, Thomas E	Columbia
PATRONE, Richard A	Students
PATTANAYAK, MD, Minati	Bucks
PATTERNAC, MD, Deborah A	Montgomery
PATTERSON, MD, Arthur J	Greene
PATTERSON, MD, Chris	Delaware
PATTERSON, MD, Cynthia M	York
PATTERSON, MD, Elizabeth A	Allegheny
PATTERSON, MD, George W	Allegheny
PATTERSON, MD, John R	Philadelphia
PATTERSON, MD, John W	Northampton
PATTERSON, MD, Joseph R	Cambria
PATTERSON, MD, Leland F	Dauphin
PATTERSON, MD, Lewis T	Dauphin
PATTERSON, MD, Michael B	Allegheny
PATTERSON, MD, Richard J	Dauphin
PATTERSON, MD, Robert J	Philadelphia
PATTERSON JR, MD, Arthur J	Greene
PATTISHALL III, MD, Evan G	Dauphin
PATTISHALL JR, MD, Evan G	Centre
PATTON, MD, Anna M	Allegheny
PATTON, MD, George D	Allegheny
PATTON, MD, Mary L	Delaware
PATUKAS, MD, Peter C	Chester
PATYK, MD, Richard A	Berks
PAUL, MD, Albert J	Philadelphia
PAUL, MD, Alvin J	Montgomery
PAUL, MD, Anthony R	Philadelphia
PAUL, MD, Boris	Monroe
PAUL, MD, George J	Northampton
PAUL, MD, Gerson S	Philadelphia
PAUL, MD, Hugo B	Allegheny
PAUL, MD, Jay	Butler
PAUL, MD, Phyllis O	Philadelphia
PAUL, MD, Richard	Allegheny
PAUL, MD, Ronald L	York
PAUL, MD, Sindy M	Philadelphia
PAUL JR, MD, John D	Lancaster
PAULETTO, MD, Ferrel J	Delaware
PAULEY, MD, Lois P	Bucks
PAULEY, MD, William G	Bucks
PAULUS, MD, George E	Dauphin
PAUTLER, MD, Stanislav	Allegheny
PAVICH, MD, Rudolph W	Cambria
PAVLIC, MD, George J	Allegheny
PAVLIDES, MD, Constantinos A	Philadelphia
PAVLIS, MD, Robert J	Allegheny
PAVSEK, MD, Edward J	Allegheny
PAVUK, MD, Daniel J	Lackawanna
PAWAR, MD, Surendra V	Allegheny
PAWELSKI, MD, Richard J	Dauphin
PAWLOSKY, MD, Frank X	Allegheny
PAYAWAL, MD, Aurora S	Philadelphia
PAYNE, MD, Virginia L	Northumberland
PEACOCK, MD, Thomas E	Northampton
PEAL, MD, Stanley	Allegheny
PEALE, MD, Augustin R	Philadelphia
PEARAH, MD, J David	Berks
PEARCE, MD, Alexander E	Philadelphia
PEARCE, MD, Steven R	York
PEARCY, MD, Cornell	Philadelphia
PEARLSTINE, MD, Beatrice	Philadelphia
PEARSON, MD, Frederick J	Northampton
PEARSON, MD, June A	Monroe
PEARSON JR, MD, Robert E	Cumberland
PEASE, MD, Fred	Clearfield
PEASE, MD, William E	Dauphin
PEBERDY, MD, Mary Ann	Philadelphia
PECHIN, MD, Sergius P	Delaware
PECHSTEIN, MD, George R	Montgomery
PECHT, MD, Karl R	Clinton
PECK, MD, William J	Lycoming
PECMAN, MD, Joanna	Allegheny
PECORARO, MD, Joseph P	Montgomery
PEDERSEN, MD, Irene A	Philadelphia
PEDIGO, MD, James M	Delaware
PEDITTO, Kathleen L	Students
PEDROTTY JR, MD, Francis W	Philadelphia
PEER, MD, Meeta D	Philadelphia
PEGEL, MD, Louis A	Montgomery
PEGUERO, MD, O Alberto	Luzerne
PEIKES, MD, Irwin L	Montgomery
PEINDL, MD, Paul M	Beaver
PEIRSEL, MD, Paul E	Somerset
PEIRSOL, MD, Betty L	Allegheny
PEITZMAN, MD, Andrew B	Allegheny
PEITZMAN, MD, Steven J	Philadelphia
PELAEZ, MD, Manuel	Fayette
PELCZAR, MD, Eugene W	Luzerne
PELEKANOS, MD, Michael J	Allegheny
PELENSKY, MD, Jeanne M	Philadelphia
PELICCI, MD, Leroy J	Lackawanna
PELKOFER, MD, Cletus G	Allegheny
PELKOWSKI, MD, David J	Bradford
PELL, MD, John J	Chester
PELL III, MD, Edward N	Somerset
PELLECCHIA, MD, Patrick E	Philadelphia
PELLEGRINI, MD, Ronald V	Allegheny
PELLEGRINI, MD, Vincent A	Berks
PELLIZZARI, MD, Rinaldo G	Erie
PELOSI, MD, Louis M	Philadelphia
PELSZYNSKI, MD, Eugene E	Philadelphia
PELTIER, MD, Hubert C	Philadelphia
PELTZ, MD, Dieter E	Montgomery
PENCHANSKY, MD, Barry H	Lancaster
PENDLETON, MD, James L	Montgomery
PENDRAK, MD, Robert F	Dauphin
PENMAN, MD, William R	Chester
PENN, MD, Samuel E	Allegheny
PENNELL JR, MD, Edgar L	Philadelphia
PENNES, MD, Edward L	Philadelphia
PENNEYS, MD, Edith T	Philadelphia
PENNOCK, MD, John L	Dauphin
PENNOCK, MD, L Lewis	Allegheny
PENNOCK, MD, Ronald S	Philadelphia
PENROD, MD, Dale S	Philadelphia
PENSIRIKUL, MD, Viroje	Washington
PENTA, MD, John M	Berks
PENUGONDA, MD, Dwaraki B	Luzerne
PENUGONDA, MD, Haragopal S	Luzerne
PEPE, MD, Peter F	Centre
PEPICELLO, MD, James A	Erie
PEPPER, MD, L Douglas	Allegheny
PEPPERMAN, MD, Larue E	Lycoming
PERALTA, MD, Juan O	Northumberland
PERCH, MD, Gerald A	Montgomery
PERCH, MD, Robert B	Montgomery
PERER, MD, William A	Allegheny
PERERA, MD, L Wimal	Montgomery
PEREZ, MD, Erlinda B	Fayette
PEREZ, MD, Godofredo B	Fayette
PEREZ, MD, Horacio A	Allegheny
PEREZ-TAMAYO, MD, Ruheri	Philadelphia
PERFETT, MD, Alfred A	Mercer
PERILSTEIN, MD, Michael D	Berks
PERIN, MD, Lawrence A	Bucks
PERIS, MD, Leon A	Philadelphia
PERIYANAYAGAM, MD, Srinivasan	Luzerne
PERKEL, MD, Robert L	Philadelphia
PERKINS, MD, Charles G	Luzerne
PERLIN, MD, Mark W	Allegheny
PERLMAN, MD, Abraham	Philadelphia
PERLMAN, MD, Henry H	Philadelphia
PERLMAN, MD, Herbert C	Cumberland
PERLMUTTER, MD, Gordon S	Berks
PERLOFF, MD, Leonard J	Philadelphia
PERLOSKI, MD, Leo	Schuylkill
PERLSTEIN, MD, Deborah A	Delaware
PERLSTEIN, MD, Samuel M	Philadelphia
PERNA, MD, Francis X	Dauphin
PERNESKI, MD, Robert L	Elk/Cameron
PEROUTKA, MD, Kathryn	Dauphin
PERPER, MD, Joshua A	Allegheny
PERRI, MD, Francis R	Allegheny
PERRI, MD, John A	Allegheny
PERRICCI, MD, Ellen S	Berks
PERRIGE, MD, William M	Northumberland
PERRIN, MD, Ronald L	Allegheny
PERRIN, MD, Samuel R	Allegheny
PERRINE, MD, Jane E	Philadelphia
PERRONE, MD, Frank F R	Fayette
PERRONE JR, MD, Frank P	Westmoreland
PERROTTA JR, Charles	Allegheny
PERROTTO, MD, Santie L	Philadelphia
PERRY, MD, Anthony M	Lackawanna
PERRY, MD, James M	Montour
PERRY, MD, John F	Chester
PERRY, MD, Ralph L	Mercer
PERRY, MD, Raymond A	Bradford
PERRY JR, John N	Allegheny
PERRYMAN, MD, Charles A	Allegheny
PERRYMAN, MD, Charles R	Allegheny
PERSHING, MD, Hugh S	Bucks
PERSIC JR, MD, Louis A	Centre
PERSING, MD, John H	Union
PERSING, MD, Kathryn C	Philadelphia
PERSING JR, MD, Harry M	Blair
PERSKY, MD, Abram H	Philadelphia
PERSON, MD, Morgan D	Lehigh
PERZLEY, MD, Richard I	Philadelphia
PESKE, MD, Edgar D	Erie
PESSOLANO, MD, Carl J	Allegheny
PESSOLANO, MD, Francis X	Somerset
PESSOLANO, MD, Frank J	Somerset
PETER, MD, Mohan	York
PETERMAN JR, DO, Ambrose B	Montgomery
PETERNEL, MD, Wayne W	Allegheny
PETERS, MD, Charles D	Lehigh
PETERS, MD, Frank S	Luzerne
PETERS, MD, Harold E	Lancaster
PETERS, MD, Jerome A	Beaver
PETERS, MD, John W	Lackawanna
PETERS, MD, Keith R	Allegheny
PETERS, MD, Leonard L	Venango
PETERS, MD, Michael	Bucks
PETERS, MD, Raymond F	Washington
PETERS, MD, Richard A	Warren
PETERS, MD, Richard J	Mercer
PETERS, MD, Robert J	Fayette
PETERS, MD, Stanley F	Bucks
PETERS, MD, Vaughan	Allegheny
PETERS, MD, Walter K	Northampton
PETERS II, MD, C A P	Lycoming
PETERS III, MD, Ray F	Bucks
PETERS JR, MD, Robert H	Luzerne
PETERSOHN, MD, J Randolph	Montgomery
PETERSOHN, MD, Jeffrey D	Philadelphia
PETERSON, MD, Arthur L	Montgomery
PETERSON, MD, Christopher J	Dauphin
PETERSON, MD, Clifford M	Erie
PETERSON, MD, Donald D	Philadelphia
PETERSON, MD, Edward N	Allegheny
PETERSON, Eric D	Allegheny
PETERSON, MD, Glenn R	Lycoming
PETERSON, MD, Karl R	Bradford
PETERSON, MD, Roger D	Lancaster
PETERSON JR, MD, Charles B	Lancaster
PETERSON JR, MD, Jay B	Westmoreland
PETILLA, MD, Mariano E	Allegheny
PETIT, MD, Charles D	Indiana
PETKUS, MD, John A	Wayne/Pike
PETRAGLIA, MD, Angelo A	Allegheny
PETRAGLIA, MD, Paul	Allegheny
PETRAGLIA, DO, Vincent F	Allegheny

PETRAUSKI, MD, Gary T	Bucks
PETRE JR, MD, John H	Erie
PETRICK, MD, Thomas P	Westmoreland
PETRIDES, MD, Anastasia B	Delaware
PETRO, MD, Dimitri M	Washington
PETRUCCELLI, MD, Nicholas D	Northampton
PETRUNCIO, MD, George J	Montgomery
PETRUSCAK, MD, Jaroslaw	Allegheny
PETT JR, MD, Stephen D	Erie
PETTAPIECE JR, MD, Milton C	Allegheny
PETTI, MD, Theodore A	Allegheny
PETTINATO, MD, Salvatore R	Lackawanna
PETTINELLI, DO, Frank P	Philadelphia
PETTIT, MD, Horace	Philadelphia
PETTIT, MD, Mary D	Philadelphia
PETZ, DO, Darrell W	Allegheny
PEVAR, MD, Joel B	Philadelphia
PEVNY, MD, Ernest	Monroe
PEW, MD, Joseph N	Berks
PEZZI, MD, Christopher M	Montour
PEZZI, MD, Pio J	Montgomery
PEZZUTI, MD, John E	Dauphin
PFAEFFLE, MD, Hugo H	Allegheny
PFEFFER, MD, William H	York
PFEFFER, MD, William H	Philadelphia
PFEIFER III, MD, William F	Westmoreland
PFEIFFER, MD, Mildred C	Philadelphia
PFEIL, MD, Russell W	Lycoming
PFISTER, MD, John A	Montgomery
PFLUGFELDER, MD, Elizabeth A	Montgomery
PFOHL, MD, David N	Philadelphia
PFRIMMER, MD, Wayne J	Allegheny
PFROMMER, MD, James H	Bucks
PHADKE, MD, Madhav V	Venango
PHADKE, MD, Usha M	Venango
PHAM, MD, Si M	Allegheny
PHAN, MD, Ngoc An	Philadelphia
PHANSE, MD, Kalyani M	Washington
PHANSE, MD, Mohan S	Allegheny
PHARR, MD, William F	Montour
PHATAK, MD, Meena V	Montgomery
PHEASANT, MD, Thomas R	Dauphin
PHELAN, MD, Gerald R	Montgomery
PHELAN, MD, Thomas I	Philadelphia
PHELAN, MD, William J	Lehigh
PHELPS, MD, William R	Erie
PHEMISTER, MD, Thurman L	Elk/Cameron
PHILBIN, MD, Joseph F	Lackawanna
PHILLIPS, MD, Howard T	Allegheny
PHILLIPS, MD, J Douglas	Dauphin
PHILLIPS, MD, Jane A	Allegheny
PHILLIPS, MD, John C	Allegheny
PHILLIPS, MD, John D	Lancaster
PHILLIPS, MD, John G	Allegheny
PHILLIPS, MD, Philip	Allegheny
PHILLIPS, MD, R Wayne	York
PHILLIPS, MD, Spencer D	Lancaster
PHILLIPS, MD, Vernon R	Dauphin
PHILLIPS, MD, William A	Philadelphia
PHILLIPS, MD, William J	Bradford
PHILLIPS, MD, William W	Allegheny
PHILLIPS III, MD, Chester A	Allegheny
PHILLIPS JR, MD, C Aiken	Allegheny
PHITAYAKORN, MD, Chit	Allegheny
PHITAYAKORN, MD, Preyaratt	Allegheny
PIATNEK-LEUNISSEN, MD, Dorothy A	Delaware
PIATT III, MD, John E	Centre
PIAZZA, MD, Michael R	Delaware
PICCINI, MD, Paul A	Dauphin
PICCONE, DO, Bruce R	Philadelphia
PICK, MD, Ernest J	Philadelphia
PICKAR, MD, James H	Warren
PICKENS, MD, Peter V	Montgomery
PICKERILL, MD, Robert G	Cambria
PICKERING, MD, Harold C	Philadelphia
PICKERING, MD, Jack E	Philadelphia
PICKLE IV, MD, Jacob H	Lehigh
PICZON, MD, Oscar Y	Lackawanna
PICZON, MD, Severino Y	Lackawanna
PIDUTTI, MD, Richard W	Cambria
PIERCE, MD, James C	Montour
PIERCE, MD, Leslie S	Westmoreland
PIERCE, MD, William S	Dauphin
PIERDON, MD, Steven B	Schuylkill
PIEROTTI, MD, Richard J	Montgomery
PIERSON, MD, Steven B	Bucks
PIERZCHALA, MD, Thomas H	Lehigh
PIETRAGALLO, MD, Louis D	Allegheny
PIFER, MD, Gerald W	Allegheny
PIGOZZI, MD, William N	Allegheny
PIKE, MD, Anne H	Philadelphia
PIKE, MD, Debra S	Indiana
PILAREK, MD, Valentine F	Luzerne
PILEWSKI, MD, Robert M	Venango
PILGRAM, MD, Philip A	Erie
PILLING IV, MD, George P	Philadelphia
PINEDA, MD, Honorio G	Fayette
PINKERTON, DO, Richard A	Cambria
PINSK, MD, Jeffrey H	Philadelphia
PINSKI, MD, Gabriel	Philadelphia
PINTIMALLI, MD, Joseph T	Philadelphia
PINTO, MD, Thomas B	Allegheny
PIOTROWSKA, MD, Lucy B	Montgomery
PIPER, MD, Donald E	York
PIPER, MD, Russell W	Washington
PIRANIAN, MD, Scott S	Beaver
PIROCH, MD, Joseph G	Crawford
PIROLI, MD, Robert J	Allegheny
PIRRELLO, MD, Anthony M	Butler
PIRRIS, MD, John	Washington
PISANO, MD, Daniel J	Philadelphia
PISTONE, MD, Gregory A	Philadelphia
PISULA JR, MD, Vincent P	Adams
PISZCZEK, MD, Joseph E	Luzerne
PITCAVAGE, MD, James G	Allegheny
PITKIN, MD, John T	Mckean
PITKOW, MD, Ronald B	Bucks
PITT, MD, Leldon P	Philadelphia
PITTENGER, MD, Mary A	Philadelphia
PITTENGER, MD, Rex A	Allegheny
PITTS, MD, William H	Armstrong
PITYK JR, MD, Peter E	Allegheny
PIWOZ, MD, Seymour	Philadelphia
PIZZANO, MD, Joseph A	Philadelphia
PIZZI, MD, Wilson B	Washington
PLACCI, MD, Carlos A	Allegheny
PLACE, MD, Elmer R	Lebanon
PLAGATA, MD, Edith M	Delaware
PLANO, DO, Vincent F	Northampton
PLASTER, MD, Ernest L	Allegheny
PLATT, MD, Benjamin B	Schuylkill
PLATT, MD, Howard A	Lackawanna
PLATT, MD, Ruth M	Philadelphia
PLAYFOOT, MD, Donald E	Lancaster
PLAZA-PONTE, MD, Mario T	Allegheny
PLESSET, MD, Marvin R	Allegheny
PLEVA, Stephanie G	Students
PLISKIN, MD, Mark	Monroe
PLOTZKER, MD, Richard I	Chester
PLOURDE, MD, Nancy K	Chester
PLOURDE, MD, Paul V	Lancaster
PLUMB, MD, James D	Centre
PLUME, MD, Theodore W	Montgomery
PLUMMER, MD, Lloyd G	Westmoreland
PLUMMER, MD, Robert A	Cambria
PLUMMER 3RD, MD, William	Chester
PLUMMER JR, MD, Robert E	Mifflin/Juniata
PLUNDO, DO, Gary P	Westmoreland
PLUNDO, DO, Larry J	Westmoreland
PLUNKETT, MD, Francis X	Allegheny
PLUTNICKI, MD, Ronald S	Lancaster
PLYMYER, MD, Ray E	Berks
POBER, MD, Hymen A	Allegheny
POBER, MD, Iren J	Allegheny
POCHAPIN, MD, Sherman W	Allegheny
PODBOY, MD, August J	York
PODELL, MD, Morris J	Philadelphia
PODOLSKY, MD, Sherman M	Philadelphia
PODRASKY, MD, David F	Bucks
POGGI, DO, Alfred J	Somerset
POHL, MD, Charles E	Lancaster
POINSARD, MD, Paul J	Philadelphia
POKORNEY, MD, Bruce H	Lancaster
POKORNEY, MD, Dale R	Mercer
POKORNY, Kathryn A	Allegheny
POLAKOFF II, MD, Pedro	Philadelphia
POLAM, MD, Chandra R	Allegheny
POLAN, MD, Simon	Philadelphia
POLANSKY, Jerrold S	Students
POLCINO, MD, Samuel C	Philadelphia
POLENTA, MD, John P	Allegheny
POLIDORA, MD, Frank C	Luzerne
POLIDORA, MD, Joseph J	Allegheny
POLIN, MD, Edward B	Philadelphia
POLINER, MD, Hime S	Northampton
POLINTAN, MD, Rodolfo S	Clearfield
POLIS, MD, Mark J	Lycoming
POLISHOOK, MD, Robert D	Philadelphia
POLK, MD, Lewis D	Philadelphia
POLK, MD, Miriam R	Dauphin
POLL, MD, David S	Philadelphia
POLLACK, MD, David S	Blair
POLLACK, MD, Dorothy J	Allegheny
POLLACK, MD, Howard M	Philadelphia
POLLER, MD, William R	Allegheny
POLLICE, MD, Philip G	Allegheny
POLLINO, MD, Vincent	Lackawanna
POLLOCK, MD, Arthur E	Blair
POLLOCK, MD, Burton H	Allegheny
POLLOCK, MD, Jeffrey L	Philadelphia
POLLOCK, MD, Michael S	Indiana
POLSKY, MD, Harry S	Montgomery
POMERANTZ, MD, Arthur H	Philadelphia
POMERANTZ, MD, Joel D	Philadelphia
POMERANTZ, MD, Marc B	Allegheny
POMERANTZ, MD, Philip A	Berks
POMMERSHEIM, MD, William J	Lawrence
POMPILIO, MD, Kenneth J	Bedford
POMPIZZI, MD, Ermin D	Philadelphia
POMPONIO, MD, Joseph G	Northampton
POND, MD, Harold S	Monroe
PONTARELLI, MD, Domenic J	Philadelphia
PONTIUS, MD, John G	Lancaster
PONTZ, MD, Jack B	Lancaster
PONTZER, MD, Herbert	Elk/Cameron
POOL, MD, Champe C	Dauphin
POOLE, MD, Jay H	Cambria
POOLE, MD, Robert	Chester
POORE, MD, George C	Potter
POORMAN, MD, S Sturgis	Montgomery
POPAT, MD, Anjana V	Dauphin
POPE, MD, Lance W	Philadelphia
POPE, Marybeth	Allegheny
POPHAL, MD, Mahlon J	Lycoming
POPKY, MD, George L	Philadelphia
POPOLOW, MD, Michael L	Montgomery
POPORAD, MD, George A	Philadelphia
POPOVICH, MD, John E	Allegheny
POPPER, MD, Paul M	Montgomery
PORCELAN, MD, Jane B	Philadelphia
PORKOLAB, MD, Frederick L	Allegheny
PORR, MD, George H	Dauphin
PORRECA, MD, Eugene G	Philadelphia
PORRECA, MD, George A	Philadelphia
PORT, MD, Brian R	Tioga
PORTER, MD, Edgar L	Chester
PORTER, MD, Lynne E	Allegheny
PORTER, MD, Mary M	Philadelphia
PORTER, MD, Paul S	Allegheny
PORTER JR, MD, William F	Lancaster
PORTMAN, MD, Mary A	Allegheny
PORTNER, MD, Jay H	Philadelphia
PORTNOW, MD, Jay M	Philadelphia
PORTZ, Matthew C	Students
POSATKO, MD, Peter C	Luzerne
POSATKO, MD, Robert J	Philadelphia
POSEY, MD, Dale M	Lancaster
POSNER, MD, Joel D	Montgomery
POSNER, DO, Michael H	Adams
POSNEY, MD, Joseph J	Mercer
POSSANZA, MD, Carl J	Lackawanna
POST, MD, Donald F	Dauphin
POST, MD, Jarvis H	Cambria
POST, MD, Robert M	Lehigh
POSTERNACK, MD, Melwyn L	Philadelphia
POSUNIAK JR, DO, Edward A	Philadelphia
POTASH, MD, George C	Lebanon
POTE JR, MD, Harry H	Cambria
POTELUNAS, MD, Clement B	Lackawanna
POTERA, MD, Leo P	Luzerne
POTKONSKI, MD, Leopold A	Berks
POTNIS, MD, Asha V	Allegheny
POTORSKI, MD, Robert D J	Luzerne
POTSIC, MD, William P	Philadelphia
POTTASH, MD, Ruben R	Philadelphia
POTTER, MD, Jeffrey N	Dauphin
POTTER, MD, Robert H	Allegheny
POTTER, MD, Robert H	Allegheny
POTTER 3RD, MD, William W	Centre
POTTER JR, MD, Howard P	Chester
POTTS, MD, Asa W	Chester
POULLIOTT, MD, Jerome W	Elk/Cameron
POUST, MD, George S	Lebanon
POUTOUS, MD, George W	Allegheny
POUX, MD, Paul T	Crawford
POWELL, MD, Edwin J	Philadelphia
POWELL, MD, James R	Allegheny
POWELL, MD, Mary M	Montgomery
POWELL JR, MD, Oscar M	Allegheny
POWER, MD, Diane T	Philadelphia
POWERS, MD, Donald V	Delaware
POWERS, MD, Victor J	Lehigh
POWERS JR, MD, Francis M	Lycoming
POZZA, MD, Nicholas J	Venango
PRABHU, MD, Anil	Allegheny
PRABHU, MD, Nalina	Allegheny
PRADHAN, MD, Anil G	Mckean
PRADHAN, MD, Ramesh S	Philadelphia
PRAGER, MD, David	Lehigh
PRALL, MD, Robert C	Philadelphia
PRANCKUN, MD, Peter J	Lancaster
PRANCKUN, MD, Peter P	Lancaster
PRASAD, MD, Ajit K	Chester
PRASAD, MD, Mahadevappa M	Butler
PRASAD, MD, Shishir C	Luzerne
PRATA, MD, James M	Allegheny
PRATT, MD, Jordan C	York
PRATT, MD, Robert S	Lancaster
PRATT, MD, Russell J	Columbia
PREATE, MD, Donald L	Lackawanna
PREBOLA JR, William R	Students
PREFER, MD, Audrey I	Philadelphia
PREHATNY, MD, John R	Philadelphia
PREININGER, MD, Edward R	Allegheny
PRELETZ, MD, Rudolph J	Northampton
PRELI, MD, Olindo J	Lackawanna
PRENDERGAST, MD, Maurice D	Beaver
PRENDERGAST, MD, Michael J	York
PRENSKY, MD, Jay G	Dauphin
PRESPER, MD, John H	Luzerne
PRESS, MD, Allan J	Allegheny
PRESS, MD, Arthur J	Delaware
PRESS JR, MD, Richard A	Bucks
PRESSMAN, MD, Edmund N	Chester
PRESSMAN, Mark J	Students
PRESSMAN, MD, Maurie D	Philadelphia
PRESSMAN, MD, Robert S	Philadelphia
PRESTEL JR, MD, Thomas F	Delaware
PRESTIFILIPPO, MD, Orazio	Northampton
PRESTON, MD, Vernon H	York
PRETTER, MD, Paul D	Allegheny
PREUCEL, MD, Robert W	Philadelphia
PRIBITKIN II, Edmund D	Students
PRICE, MD, Albert C	Lancaster
PRICE, MD, Alfred R	Allegheny
PRICE, MD, Edwin M	Somerset
PRICE, MD, Joseph J	Delaware
PRICE, MD, Joseph W	Philadelphia
PRICE, MD, Karen A	Bradford
PRICE, MD, Raphael I	Philadelphia
PRICE, MD, Richard E	Cambria
PRICE, MD, Richard T	Bucks
PRICE, MD, William A	Allegheny
PRICE JR, MD, Henry L	Philadelphia
PRICE JR, MD, Stuart E	Allegheny
PRICENER, Valerie M	Allegheny
PRICKETT, MD, John A	Bucks
PRIMIANO, MD, George A	Monroe
PRIN, MD, William	Allegheny
PRIN, MD, William A	Adams
PRINCE, MD, Edward R	Centre
PRINCE, MD, Richard B	Philadelphia
PRINGLE, MD, Robert W	Allegheny
PRIOLETTI, MD, John P	Lawrence
PRIORE, MD, Robert M	Allegheny
PRISTAS, MD, Michael S	Schuylkill
PRITT, MD, Pauline	Montgomery
PRITTS, MD, Rose M	Westmoreland
PROBST, MD, Susan J	Berks
PROCACCI, MD, Pasquale M	Philadelphia
PROCOPIO, MD, Frank	Dauphin
PROKHOV, MD, Vassil K	Allegheny
PROMISLOFF, DO, Robert A	Philadelphia
PROMUBOL, MD, Yuwaree	Westmoreland
PROOTHI, MD, Subhash C	Lehigh
PROPST, MD, Harry D	Wayne/Pike
PROPST-PROCTOR, MD, Sandra L	Wayne/Pike
PROROK, MD, Joseph J	Lehigh
PROSAPIO, Philip L	Students
PROSERPI, MD, Sergio V	Berks
PROSSER, MD, John O	Blair
PROSTKO, MD, E Richard	Allegheny
PROUDFIT, MD, J Paul	Washington
PROVENCIO, MD, Florencio	Lebanon
PROWELL, MD, Joseph W	Lancaster
PROY, MD, Bernard C	Erie
PRUCHNIC, MD, William F	Cambria
PRUITT, MD, John D	Montgomery
PRUSAKOWSKI, DO, Joseph M	Clarion
PRUTZMAN, MD, L Donald	Chester
PRYOR JR, MD, Charles A	Bucks
PRYSTOWSKY, MD, Harry	Dauphin
PRYSTOWSKY, MD, Janet H	Montgomery
PUBLICKER, MD, Mark R	Allegheny
PUCEVICH, MD, Maria V	Allegheny
PUGH, MD, James E	Philadelphia
PUGLIESE, MD, August A	Armstrong
PUGLIESE, MD, Joseph F	Luzerne
PUGLISI, MD, Anthony S	Philadelphia
PUGLISI, MD, Vincent	Philadelphia
PUHALLA, MD, Cyril M J	Lackawanna
PUIG-ANTICH, MD, Joaquim	Allegheny
PUJARA, MD, Mahendra M	Schuylkill
PULEIO, Donna V	Allegheny
PULLEKINES, Joseph W	Allegheny
PULLEN, MD, Harvey T	Monroe
PUMA, MD, Samuel J	Luzerne
PUNDIAK, MD, Terry J	Northampton
PUPI, MD, Paul A	Beaver
PURDUM III, MD, Preston P	Philadelphia
PURDY, MD, Richard T	Lancaster
PURKAYASTHA, MD, Arindam	Susquehanna
PURNER JR, DO, William M	Delaware
PURPURA, MD, Thomas R	Allegheny
PURSELL, MD, Robert N	Northampton
PUSATERI JR, MD, Joseph P	Allegheny
PUSCHAK, MD, Russell B	Lehigh
PUSHKAREWICZ, MD, Michael J	Philadelphia
PUTHAWALA, MD, Anwer H	Montour
PUTMAN, MD, George W	Lawrence
PUTNAM, MD, Richard C	Philadelphia
PUTPRUSH, MD, Joseph R	Luzerne
PUTTERMAN, MD, Karen G	Philadelphia
PYATT JR, MD, Robert S	Franklin
PYTKO, MD, Valentine F	Montour
PYUN, MD, Kwang W	Luzerne

Q

QUAGLIO, MD, Nannette D	Mercer
QUAIL, MD, Dorothy M	Philadelphia
QUALLS, MD, Donald M	Philadelphia
QUATTRONE, MD, Paul C	Philadelphia
QUDDAS, MD, Abdul I	Schuylkill
QUDDUS, MD, Adeeba S	Schuylkill
QUERCI, DO, John C	Luzerne
QUEREAU, MD, J Van Dyke	Berks
QUERIMIT, MD, Jorge A	Lycoming
QUESADA, MD, Manuel F	Dauphin
QUICKEL, MD, Kenneth E	Dauphin
QUIETSON-RAVANO, MD, Paraluman R	Allegheny
QUILL, MD, Joseph R	Montgomery
QUILO, MD, Felicidad F	Northampton
QUILO, MD, Lino S	Northampton
QUINEY JR, MD, James J	Northampton
QUINLIN, MD, Robert F	Allegheny
QUINN, MD, Dianne M	Bucks
QUINN, MD, Donn R	Northampton
QUINN, MD, Graham E	Philadelphia
QUINN, MD, John R	Cambria
QUINN, DO, Philip L	Mifflin/Juniata
QUINN JR, MD, Norman J	Montgomery
QUINT, MD, Donald H	Allegheny
QURASHI, MD, Sultana K	Bucks

R

RAAB, MD, David B	Lancaster
RAAB, MD, Michael F	Northampton
RABIN, MD, Harold S	Dauphin
RABIN, MD, Sidney C	Chester
RABINOWITZ, MD, Howard K	Philadelphia
RABINOWITZ, MD, Jerry P	Allegheny
RABSON, MD, Joseph A	Montgomery
RABSON, MD, Moses	Philadelphia
RACCIATO, MD, Peter J	Monroe

RACH, MD, Joel F	Philadelphia
RACHO, MD, George J	Luzerne
RACKOW, MD, Lawrence L	Philadelphia
RADBILL, MD, Samuel X	Philadelphia
RADBILL, MD, Sidney G	Philadelphia
RADECKI, MD, Paul D	Philadelphia
RADER, MD, Mark D	Lehigh
RADFAR, MD, Nezam	Allegheny
RADFAR, MD, Rouhangiz H	Allegheny
RADICE, MD, Eugene D	Columbia
RADIO, MD, Gregory J	Lehigh
RADKE, MD, Timothy A	Philadelphia
RADLER, MD, John K	Beaver
RADSMA, MD, Douwe L	Adams
RAEUCHLE, DO, Randal A	Dauphin
RAFALKO, MD, David M	Beaver
RAFFENSPERGER, MD, Bruce W	Philadelphia
RAGER, MD, Ronald	Allegheny
RAGGI, MD, Fiora	Philadelphia
RAGGIO, MD, Tanya	Washington
RAGHEB, MD, Youssef S	Allegheny
RAGONESI, MD, Susan B	Philadelphia
RAGOOWANSI, Ashvin T	Allegheny
RAGOOWANSI, MD, Tulsidas N	Beaver
RAHAM, MD, David C	Dauphin
RAHAUSER, MD, David M	Franklin
RAHNER, MD, Richard A	Erie
RAI, MD, Balbinder S	Allegheny
RAI, MD, Rajes H	Lehigh
RAICH, MD, William A	Lancaster
RAIFORD, MD, John W	Bucks
RAINES, MD, Herbert S	Philadelphia
RAINEY, MD, Edward C	Blair
RAISCH, MD, Frederick J	Mercer
RAIZMAN, MD, Richard E	Allegheny
RAJ, MD, Dhan	Warren
RAJ, MD, Stephen S	Erie
RAJA, MD, Rasib M	Philadelphia
RAJAN, MD, Sanda	Chester
RAJARATNAM, MD, Emma P	Philadelphia
RAJASENAN, MD, Vasudevan	Lawrence
RAJJOUB, MD, Rodwan K	Lycoming
RAJU, MD, Rudraraju P	Blair
RAKLEWICZ, MD, Michael C	Luzerne
RALPH, MD, Nathan	Philadelphia
RALSTON, MD, Edgar L	Philadelphia
RALSTON, MD, Emerald M	Erie
RALSTON, MD, James C	Fayette
RAM, MD, Sant	Erie
RAMAGE, MD, Ann L	York
RAMAKRISHNA, MD, Nagamalli	Allegheny
RAMAKRISHNA, MD, Srinivasarao	Lackawanna
RAMAN, MD, Asha	Allegheny
RAMAN, MD, Gita S	Bradford
RAMASASTRY, MD, Sai S	Allegheny
RAMBACH, MD, Leonard	Lancaster
RAMESH, MD, Makum L	Allegheny
RAMIK, MD, Otto E	Allegheny
RAMIREZ, MD, Constancio	Franklin
RAMIREZ, MD, Renato P	Crawford
RAMOS, MD, Clarita P	Allegheny
RAMOS-TARAMPI, MD, Lourdeline G	Philadelphia
RAMOSKA, MD, Edward A	Philadelphia
RAMS, MD, James J	Allegheny
RAMSEY II, MD, William H	Montgomery
RAMSEY JR, MD, Harry E	Berks
RANA, MD, Nilesh C	Philadelphia
RANCIER, MD, Lee F	Lackawanna
RANCK, MD, Sidney G	Bradford
RANDALL, MD, J Perlingiero	Montgomery
RANDALL, MD, Peter	Philadelphia
RANDALL IV, MD, Alexander	Montgomery
RANIERI, MD, Tito A	Philadelphia
RANII, MD, Carmello A	Allegheny
RANKIN, MD, James S	Allegheny
RANKIN, MD, Kevin P	Centre
RANKIN, MD, Larry S	Cumberland
RANKIN, MD, Paul H	Mercer
RANKIN, MD, Robert C	Allegheny
RANKIN, MD, Samuel G	Allegheny
RANKIN, MD, Thomas V	York
RANNELS, MD, Herman W	Lycoming
RAO, MD, B Venkat	Allegheny
RAO, MD, Gutti P	Westmoreland
RAO, MD, Kasuganti V	Allegheny
RAO, MD, Leela K	Allegheny
RAO, MD, Madhava S	Lackawanna
RAO, MD, Nalini G	Allegheny
RAO, MD, Ramdev K	Allegheny
RAO, MD, T Gopal	Allegheny
RAO, MD, Usha G	York
RAPHAEL, MD, Paul S	Lehigh
RAPHAELY, MD, Russell C	Philadelphia
RAPOPORT, MD, Abraham M	Montgomery
RAPPAPORT, MD, Melvin M	Lehigh
RASANSKY, MD, Harry N	Philadelphia
RASCOE JR, MD, Robert R	Philadelphia
RASHID, MD, Abdul	Schuylkill
RASHID, MD, Ayesha	Allegheny
RASHID, MD, Shaik A	Westmoreland
RASHKIS, MD, Harold A	Philadelphia
RASO, MD, Dominic J	Northampton
RASTI, MD, Reza	Allegheny
RATHGEB, MD, John M	Westmoreland
RATKE, MD, Henry V	Lycoming
RATNER, MD, Jeffrey A	Centre
RATNER, MD, Richard R	Delaware
RAU, MD, Ramnath S	Mercer
RAU, MD, Raymond L	Allegheny
RAUB, MD, James A	Allegheny
RAUB, MD, Jeffrey D	Venango
RAUCH, MD, Douglas	Mercer
RAUER, MD, Lester	Philadelphia
RAVANO, MD, Jose F	Allegheny
RAVEL, MD, Robert L	Montgomery
RAVETZ, DO, Robert S	Philadelphia
RAVICHANDRAN, MD, Chitra R	Luzerne
RAVITCH, MD, Mark M	Allegheny
RAVITZ, MD, Gerald A	Schuylkill
RAWNSLEY, MD, Herbert H	Washington
RAWSON, MD, Helen H	Montgomery
RAY, MD, Richard L	Allegheny
RAY, MD, Tarun K	Philadelphia
RAYMOND, MD, Joseph W	Cambria
RAYMOND, MD, Paul A	Cambria
RAYMOND JR, MD, Fred D	Montgomery
RAYMUNDO, MD, Rosalinda R	Lawrence
RAYMUNDO III, MD, Ricardo B	Lawrence
RAYNAK, MD, Frank R	Mercer
RAYNER, MD, Mark E	Philadelphia
RAYNOR, MD, B Denise	Philadelphia
RAZA, MD, Hyder S	Carbon
RAZURI, MD, Rafael G	Northampton
READ, MD, Stephen G	Allegheny
REAGAN, MD, Marie A	Allegheny
REAL, MD, Adelina	Philadelphia
REAL, MD, Mark B	Chester
REAMER, MD, Donald M	Venango
REAMS, MD, Carl L	Montour
REARDON, MD, Paul L	Washington
REBER, MD, Howard F	Berks
RECH, MD, Frank M	Delaware
RECH, MD, Susan A	Philadelphia
RECIK, MD, Halit	Philadelphia
RECIO, MD, Conrado M	Erie
RECIO, MD, Rolando G	Allegheny
RECKER, MD, Scott F	Allegheny
RECTOR, MD, Robert D	Franklin
RED, MD, Donald E	Delaware
REDA, MD, Frank A	Allegheny
REDDING, MD, Willis A	Bradford
REDDY, MD, Jaiveer T	Clarion
REDDY, MD, Patricia A	Dauphin
REDDY, MD, Pushpamala P	Armstrong
REDDY, MD, Rajidi M	Lycoming
REDDY, MD, Subash C	Philadelphia
REDDY, MD, V Saraswathi	Bradford
REDEL, MD, Walter A	Lackawanna
REDENBAUGH, MD, James E	Lehigh
REDKA, MD, James W	Lycoming
REECE, MD, William W	Philadelphia
REED, MD, Cheryl A	Beaver
REED, MD, Clifford A	Berks
REED, MD, Darrell K	Allegheny
REED, MD, David E	Allegheny
REED, MD, David M	Allegheny
REED, MD, David T	Montgomery
REED, MD, Elmer M	Centre
REED, MD, Janis E	Allegheny
REED, MD, Lola S	Chester
REED, MD, Mark S	Berks
REED, MD, Michael F	Clearfield
REED, MD, Peter W	Philadelphia
REED, MD, Theodore P	Philadelphia
REED, MD, W Glenn	Allegheny
REEFER, MD, John C	Butler
REEKIE, MD, Timothy G	Philadelphia
REEL, MD, Charles M	Westmoreland
REES, MD, David B	Berks
REESE, MD, Edward F	Allegheny
REESE, MD, Fred W	Columbia
REESE, MD, Jack W	Cambria
REESE, MD, Richard W	Lancaster
REESE, MD, Walter D	Philadelphia
REESE, MD, Warren S	Philadelphia
REESE JR, MD, Evan C	Northampton
REFOWICH, MD, Richard S	Northampton
REGALADO, MD, Regulus D	Union
REGAN, MD, James R	Northampton
REGANIS, MD, John C	Northampton
REGEC, MD, Stephen P	Elk/Cameron
REH, MD, Richard C	Cumberland
REHEIS, MD, John P	Philadelphia
REHFUSS, MD, Kathleen L	Dauphin
REICH, MD, Harry	Luzerne
REICH, MD, Sylvia R	Luzerne
REICH, MD, William P	Tioga
REICHARD, MD, James L	Centre
REICHARD, MD, Richard C	Berks
REICHLE, MD, Frederick A	Philadelphia
REICHMAN, MD, Joseph H	Montgomery
REIDELL, MD, John S	Centre
REIDENBERG, MD, Leon	Berks
REIFSNYDER, MD, William H	Berks
REIGART, MD, Paul M	York
REIGEL, MD, Donald H	Allegheny
REIGH, MD, Ernest E	Berks
REIHELD-ERNEY, MD, Lynn L	Philadelphia
REILLY, MD, Ann E	Chester
REILLY, MD, Charles M	York
REILLY, MD, Desmond J	Dauphin
REILLY, MD, James J	Allegheny
REILLY, MD, James S	Allegheny
REILLY, MD, John C	Erie
REILLY, MD, Phillip E	Fayette
REILLY JR, MD, James J	Allegheny
REILLY JR, MD, Philip J	Westmoreland
REILLY JR, MD, William M	Washington
REINBOLD, MD, Raymond L	Montgomery
REINECKE, MD, Robert D	Philadelphia
REINERS, MD, Charles R	Huntingdon
REINHARD, MD, Ronald J	York
REINHARDT, MD, Pauline K	Lehigh
REINHART, MD, John W	Lehigh
REINHART JR, MD, Raymond B	Bucks
REINMUTH, MD, Oscar M	Allegheny
REINPRECHT, MD, James T	Philadelphia
REINSEL, MD, Richard C	Berks
REIS, MD, Claude J	Allegheny
REIS, MD, Paul B	Lycoming
REIS, MD, Walter J	Allegheny
REISH, MD, William G	Union
REISINGER, MD, Susan A	Philadelphia
REISINGER JR, MD, William E	Washington
REISMAN, MD, Edward D	Allegheny
REITANO JR, MD, Joseph F	Delaware
REITER, MD, David	Philadelphia
REITSMA, MD, Douglas B	Delaware
REITZ, MD, John D	Beaver
REITZ, MD, Melvin L	Schuylkill
RELIGIOSO, MD, Eloisa P	Westmoreland
RELIGIOSO, MD, Erson L	Westmoreland
RELUZ, MD, Javier S	Montgomery
REMALY, MD, Donald A	Columbia
REMICK, DO, Paul F	Lackawanna
REMSBURG, Stacia T	Students
RENALDO, DO, Thomas J	Delaware
RENDEL, MD, Michael T	Philadelphia
RENDIN, MD, Larry J	Delaware
RENDON, MD, Roberto	Bucks
RENINGER, MD, Charles W	Lehigh
RENKERT, MD, Elizabeth E	Berks
RENNY, MD, Andrew	Lackawanna
RENO, MD, Joseph D	Delaware
RENSIMER, MD, Wayne T	Bradford
RENTON, MD, Alan C	Allegheny
RENTSCHLER, MD, Henry D	Bradford
RENZ, MD, Robert T	Erie
RENZI, MD, Anthony M	Philadelphia
REPICE, MD, Ronald M	Delaware
REPPERT, MD, William D	Northampton
RESHMI, MD, Chandrappa S	Allegheny
RESNICK, MD, Albert B	Philadelphia
RESNICK, MD, Edward J	Philadelphia
RESNICK, MD, George J	Philadelphia
RESNICK, MD, Myron E	Delaware
RESNICK, MD, Paul H	Allegheny
RESNIK, MD, Alan M	Philadelphia
RESTAK, MD, Lewis J	Adams
RESURRECCION, MD, Rosario	Philadelphia
RETTIG, MD, Stephen J	Franklin
REUBEN, MD, Mark S	Berks
REVAK, MD, Blairanne H	Columbia
REVAK, MD, Conrad S	Allegheny
REVAK, DO, David J	Columbia
REVELS, MD, Stephanie M	Allegheny
REX, MD, Eugene B	Montgomery
REX, MD, James C	Lehigh
REX, MD, Richard O	Philadelphia
REXRODE, MD, William O	York
REYES, MD, Alfredo M	Cambria
REYES, MD, John W	Greene
REYES, MD, Saturnino M	Beaver
REYES, MD, Vicente E	Allegheny
REYNA, MD, Oscar D	Westmoreland
REYNOLDS, John W	Students
REZNAK, MD, Stephen E	Philadelphia
RHEE, MD, Ky Y	Fayette
RHIEW, MD, Francis C	Lackawanna
RHOADES, DO, Dennis W	Jefferson
RHOADS, MD, Donald V	Philadelphia
RHOADS, MD, Harry M	Cambria
RHOADS, MD, Jonathan E	Philadelphia
RHOADS JR, MD, Jonathan E	Philadelphia
RHODE, MD, Marvin C	Montgomery
RHODES, MD, Michael	Lehigh
RHODES, MD, Robert A	Delaware
RHODES III, MD, Luther V	Lehigh
RHOOD, MD, Samuel G	Delaware
RIAL, MD, William Y	Delaware
RICCHETTI, MD, Robert J	Philadelphia
RICCHIUTI, MD, A George	Schuylkill
RICCHIUTI, MD, Joseph F	Schuylkill
RICCI, MD, Joseph A	Dauphin
RICCI, MD, Michael A	Bradford
RICCIUTTI, MD, Vincent	Mercer
RICCO, MD, Ernest J	Philadelphia
RICE, MD, Donald H	Blair
RICE, MD, Eileen M	Allegheny
RICE, MD, Samuel A	Lancaster
RICE, MD, Samuel M	Allegheny
RICH, MD, Dean C	Montgomery
RICH, MD, James F	Dauphin
RICHARD, MD, David C	Montour
RICHARDS, MD, Charles H	Allegheny
RICHARDS, MD, Frederick H	Bradford
RICHARDS, MD, Harry L	Allegheny
RICHARDS, MD, John C	Bucks
RICHARDS, MD, Nelson M	Allegheny
RICHARDS, MD, Robert N	Franklin
RICHARDS JR, MD, Robert N	Franklin
RICHARDSON, MD, Claude E	Delaware
RICHARDSON, MD, George A	Philadelphia
RICHARDSON, MD, George S	Allegheny
RICHARDSON, MD, Harrison H	Beaver
RICHARDSON, MD, James E	Washington
RICHARDSON, MD, Paul A	Philadelphia
RICHARDSON, MD, Roosevelt	Allegheny
RICHARDSON, MD, Ross E	Washington
RICHEY, MD, James E	Cambria
RICHIE, MD, A Thomas	Bucks
RICHMAN, MD, Kenneth A	Philadelphia
RICHMOND, MD, Allen C	Philadelphia
RICHMOND, MD, Spencer I	Montgomery
RICHTER, MD, Howard A	Delaware
RICHTER, MD, Melvyn P	Philadelphia
RICHTER, MD, Paul L	Allegheny
RICHTER, MD, Tor	Allegheny
RICK JR, MD, William J	Luzerne
RICKELS, MD, Karl	Philadelphia
RICKETTS, MD, J Edward	Allegheny
RICKLOFF, MD, Raymond J	Erie
RIDELLA, MD, Peter J	Cambria
RIDEN, MD, Jay M	Mifflin/Juniata
RIDGWAY, MD, William G	Lancaster
RIDOUT III, MD, Daniel L	Philadelphia
RIEGEL, MD, George E	Allegheny
RIEMER, MD, Barry L	Allegheny
RIEMER, MD, Joseph T	Montgomery
RIENZO, MD, Robert J	Lehigh
RIES, MD, Anthony N	Philadelphia
RIETHER, MD, Robert D	Lehigh
RIETHMILLER, MD, Grace L	Allegheny
RIFE, MD, Charles J	Dauphin
RIFFERT, MD, Paul M	Lancaster
RIFKIN, MD, Matthew D	Philadelphia
RIGANO JR, MD, Rudolph F	Lancaster
RIGG, MD, L Isobel	Philadelphia
RIGHTMYER, MD, John N	Berks
RIGHTOR, MD, John T	Venango
RIGHTS, MD, Theodore H	Berks
RIGNEY JR, MD, James H	Bucks
RIKE, MD, Paul M	Allegheny
RILEY, MD, Bernard J	Allegheny
RILEY, MD, Cyril A	Philadelphia
RILEY, MD, Veryl M	Warren
RILLING, MD, David C	Bucks
RIM, MD, Jeung K	Lebanon
RIMPLE, MD, David F	Luzerne
RINARD, MD, Graffious L	Bedford
RINCK II, MD, George W	Union
RINEHIMER JR, MD, John S	Wyoming
RING, MD, Ilona R	Delaware
RING, MD, Stephen I	Delaware
RINGAWA, MD, Peter E	Columbia
RINGOLD, MD, Murray H	Bucks
RINKER, MD, R James	York
RIOFSKI, MD, Anthony F	Luzerne
RIPEPI, MD, Anthony C	Allegheny
RIPEPI, MD, Philip P	Allegheny
RIPLEY, MD, Peter M	Allegheny
RIPPLE, MD, Paul H	Lancaster
RISER, MD, Sharon J	Philadelphia
RISHI, MD, Usha S	Allegheny
RISING, MD, David C	Bucks
RISMILLER, MD, Ross W	Schuylkill
RISSER, MD, Mark G	Berks
RITCHIE, MD, Charles A	Delaware
RITCHIE, MD, David J	Philadelphia
RITCHIE, MD, Laurence T	Allegheny
RITCHIE, MD, William G	Philadelphia
RITCHIE III, MD, John C	Philadelphia
RITCHIE JR, MD, Wallace P	Philadelphia
RITTENHOUSE, MD, Emory A	Allegheny
RITTENHOUSE, Eric R	Students
RITTENHOUSE, MD, Frank H	Allegheny
RITTENHOUSE, MD, George H	Allegheny
RITTER, MD, Charles W	Philadelphia
RITTER, MD, Deborah E	Philadelphia
RITTER, MD, Elaine M	Westmoreland
RITTER, MD, Joseph G	Montgomery
RITTER, MD, Mario	Cambria
RITTER, MD, Thomas J	Schuylkill
RIVAS-FLORES JR, MD, Aureliano	Montgomery
RIVERA, MD, Edwin A	York
RIVERA, Jose M	Students
RIVERA, MD, Victor C	Bucks
RIVERO, MD, Hedrick J	Allegheny
RIVIELLO JR, MD, James J	Philadelphia
RIZK, MD, Wafa I	Washington
RIZZARDI, MD, Roger N	Erie
RIZZO, MD, John S	Delaware
RIZZO, MD, Samuel V	Luzerne
ROACHE, MD, Martin J	Chester
ROBB, MD, Marie E	Northampton
ROBBINS, MD, Howard S	Lancaster
ROBBINS, MD, Mark S	Philadelphia
ROBBINS, MD, Michael E	Dauphin
ROBBINS, MD, Robert	Philadelphia
ROBBINS, MD, Warren J	Lancaster
ROBBINS, MD, William S	Philadelphia
ROBERTS, MD, Brooke	Philadelphia
ROBERTS, MD, Haskell E	Lancaster
ROBERTS, MD, Joan M	Philadelphia
ROBERTS, MD, John M	Philadelphia
ROBERTS, MD, Linda P	Westmoreland
ROBERTS, MD, Michael C	Montgomery
ROBERTS, MD, Richmond C	Chester
ROBERTS, MD, William D	Lancaster
ROBERTS JR, Douglas J	Lackawanna
ROBERTS JR, MD, Philip G	Centre
ROBERTSON, MD, J Alan	Allegheny
ROBERTSON, MD, John J	Berks
ROBERTSON, MD, John L	Warren
ROBERTSON, MD, John W	Philadelphia
ROBIN, DO, F Philip	Philadelphia

ROBINS, MD, Donald E Allegheny
ROBINS, MD, Hugh B Allegheny
ROBINS, MD, Isadore M Luzerne
ROBINSON, MD, Frederick A Philadelphia
ROBINSON, MD, Gary Berks
ROBINSON, MD, James H Philadelphia
ROBINSON, MD, James P Schuylkill
ROBINSON, MD, Jay A Blair
ROBINSON, MD, John N Allegheny
ROBINSON, MD, Joseph Luzerne
ROBINSON, MD, Leslie E York
ROBINSON, MD, Leslie S Philadelphia
ROBINSON, MD, Nathaniel M Philadelphia
ROBINSON, MD, Richard F York
ROBINSON, MD, William P Philadelphia
ROBINSON JR, MD, Elliott S Bradford
ROBINSON JR, MD, James J Philadelphia
ROBISON, MD, Robert N Dauphin
ROBLES, Robert L Students
ROBSON, Peter A Students
ROCCARIO, DO, Dante S Delaware
ROCCO, MD, Nicholas J Philadelphia
ROCHE, MD, Charles A Allegheny
ROCHE, MD, Karen R Allegheny
ROCHE, MD, Robert J Erie
ROCHE JR, MD, Edward J Mckean
ROCK, Edwin P Allegheny
ROCK, MD, Elizabeth D Chester
ROCK, MD, James A Cambria
ROCK, MD, Leonard L Somerset
ROCKOWER, MD, Roger A Centre
RODA, DO, David M Lancaster
RODA, MD, Paul I Luzerne
RODENBERGER, MD, Bruce M Lehigh
RODGERS, MD, Allan F Philadelphia
RODGERS, MD, Charles J Lycoming
RODGERS, MD, David M Philadelphia
RODGERS, MD, Edson R Beaver
RODGERS, MD, Florence E Philadelphia
RODGERS, MD, Joseph F Philadelphia
RODGERS, Margaret L Students
RODGERS, MD, Thomas P Clinton
RODGERS 3RD, MD, William H Montgomery
RODIGAS, MD, Paul C Philadelphia
RODMAN, MD, Theodore Philadelphia
RODRIGUEZ, MD, Adolfo E Berks
RODRIGUEZ, MD, Dolores E Montour
RODRIGUEZ, MD, Edsel A Northumberland
RODRIGUEZ, George L Students
RODRIGUEZ, MD, Julio A Blair
RODRIGUEZ, MD, Pedro Allegheny
RODRIGUEZ, MD, Raymond Philadelphia
RODRIGUEZ, MD, Rodolfo E Dauphin
RODRIGUEZ-OQUENDO, MD, Annabelle Philadelphia
ROE, MD, Eugene J Lackawanna
ROE, MD, Hans S Cumberland
ROE, MD, Jacqueline F Lancaster
ROEDDER, MD, Susan L Philadelphia
ROEDER, MD, Donald K Cumberland
ROEDER, MD, Kathleen M Bucks
ROEDIGER, MD, Paul M Montgomery
ROFMAN, MD, Barry A Montgomery
ROGAL, MD, Anne P York
ROGAL, MD, Michael J Allegheny
ROGALLA, MD, Charles S Lackawanna
ROGERS, MD, Albert K Lancaster
ROGERS, MD, George E Cambria
ROGERS, MD, Hugh J Centre
ROGERS, MD, James F Philadelphia
ROGERS, MD, John F Northampton
ROGERS, MD, Jonathan J Montgomery
ROGERS, MD, Joseph C Montgomery
ROGERS, MD, Kenneth D Allegheny
ROGERS, MD, Kenneth J Centre
ROGERS, MD, Pamela Y Beaver
ROGERS, MD, Paul H Chester
ROGERS, MD, R Claude Philadelphia
ROGERS, MD, Steven Allegheny
ROGERS, MD, Vincent P Erie
ROGERS JR, MD, Robert M Armstrong
ROGERSON, MD, David R Cambria
ROGEVICH, DO, Joseph E Lancaster
ROGOFF, MD, Philip A Philadelphia
ROGOW, MD, Edward Allegheny
ROGOWSKI, MD, Raymond A Chester
ROHATGI, MD, Rajeev Northampton
ROHLAND, MD, Donald V Dauphin
ROHM, MD, Jack Z Allegheny
ROHNER JR, MD, Thomas J Dauphin
ROHRABAUGH JR, MD, Charles M Dauphin
ROHRBECK, MD, Charles W Centre
ROHRER, MD, G Victor Dauphin
ROITMAN, MD, Harry B Philadelphia
ROJAS, MD, Julio R Luzerne
ROJER, MD, Charles L Montgomery
ROKE, MD, Albert D Berks
ROLAND, MD, Frederick H Lehigh
ROLLINGS, Ruth E Students
ROLLINS, MD, Clark T Allegheny
ROLLMAN, Bruce L Students
ROLLO, MD, Daniel P Lebanon
ROMAN, MD, Laurian Philadelphia
ROMAN, MD, Stephen J Westmoreland
ROMANO, Janet E Students
ROMANO, MD, Joseph M Allegheny
ROMANO, MD, Vincent E Bucks
ROMANO JR, MD, Nicholas M Northampton
ROMANO-JANA, MD, Lourdes R Erie
ROMANOW, MD, Peter W Philadelphia
ROMANZO, MD, George M Montgomery
ROMBEAU, MD, John L Philadelphia
ROMBERGER, Charles F Students
ROMEIKA, MD, Mary M Schuylkill
ROMEO, MD, Victoria J Clinton
ROMIG, MD, Ronald S Berks
ROMINGER, MD, C Jules Chester
ROMMEL, MD, Catherine T Montour
ROMMEL, MD, Frank L Allegheny
ROMY, MD, Maurice I Philadelphia
RONCO, DO, Domenick N Union
RONGAUS, MD, William J Washington
RONIS, MD, Bernard J Philadelphia
RONIS, MD, Max L Philadelphia
RONNERMANN, MD, Drew P Montgomery
ROODE, MD, Albert G Venango
ROODE, MD, Philip J Venango
ROOKLIN, MD, Anthony R Delaware
ROONEY, MD, Edward F Allegheny
ROONEY, MD, Joseph W Beaver
ROOS, MD, Alfred T Erie
ROOS, MD, Leon Adams
ROPPOLO, MD, Helen M Allegheny
ROQUIZ, MD, Eliseo M Erie
RORICK, MD, Nicholas R Montgomery
RORKE III, MD, John H Chester
ROS, MD, Nydia C Allegheny
ROSA, Deborah M Students
ROSALES, MD, Gabriel B Bucks
ROSAN, DO, Jay R Montgomery
ROSARIO-LEON, MD, Nelson R Dauphin
ROSATI, Anthony V Students
ROSATO, MD, Donald J Chester
ROSATO, MD, Ernest F Philadelphia
ROSATO, MD, Francis E Philadelphia
ROSCH, MD, Jeffrey M Centre
ROSCH, MD, Julius C Blair
ROSCHEL, MD, Robert L Lancaster
ROSCHER, MD, Atilio R Northampton
ROSCKOWFF, MD, Carol M Luzerne
ROSCOE, MD, Constantine Philadelphia
ROSCOE, MD, Diane L Philadelphia
ROSCOE, MD, Francis W Lackawanna
ROSCOE, MD, Gregory J Jefferson
ROSE, MD, Carol E Allegheny
ROSE, MD, David Montgomery
ROSE, MD, Edward Philadelphia
ROSE, MD, Elizabeth K Philadelphia
ROSE, MD, Frederick B Bradford
ROSE, MD, Henry S Philadelphia
ROSE, MD, Isadore Philadelphia
ROSE, MD, John F Montour
ROSE, MD, Leslie I Philadelphia
ROSE, MD, Lewis J Philadelphia
ROSE, MD, Robert M Montgomery
ROSEBERRY, MD, Philip L York
ROSEMAN, MD, Richard L Philadelphia
ROSEMOND, MD, George P Philadelphia
ROSEN, MD, Albert C Philadelphia
ROSEN, MD, Bruce J Delaware
ROSEN, MD, Daniel H Venango
ROSEN, MD, David Philadelphia
ROSEN, MD, Glenn D Philadelphia
ROSEN, MD, Harvey M Philadelphia
ROSEN, MD, Jacob C Philadelphia
ROSEN, MD, James A Westmoreland
ROSEN, MD, John N Bucks
ROSEN, MD, Joseph H Philadelphia
ROSEN, MD, Leonard Delaware
ROSEN, MD, Lester Lehigh
ROSEN, MD, Lisa S Philadelphia
ROSEN, MD, Marc R Philadelphia
ROSEN, MD, Marvin I Philadelphia
ROSEN, MD, Rhoda Philadelphia
ROSEN, MD, Steven M Philadelphia
ROSEN, MD, William Erie
ROSENBACH, MD, Loren M Allegheny
ROSENBAUM, MD, Aron Cambria
ROSENBAUM JR, MD, Leon Philadelphia
ROSENBERG, MD, Carol A Erie
ROSENBERG, MD, Cynthia N Allegheny
ROSENBERG, MD, Frank Delaware
ROSENBERG, MD, Henry Philadelphia
ROSENBERG, MD, Howard D Lehigh
ROSENBERG, MD, Irvin E Luzerne
ROSENBERG, MD, Irving Philadelphia
ROSENBERG, MD, Kenneth C Philadelphia
ROSENBERG, MD, Lawrence S Cambria
ROSENBERG, MD, Manuel Philadelphia
ROSENBERG, MD, Mark M Montgomery
ROSENBERG, MD, Morton Philadelphia
ROSENBERG, MD, Paul E Philadelphia
ROSENBERG, MD, Paul R Allegheny
ROSENBERG, MD, Philip Montgomery
ROSENBERG, MD, Philip Philadelphia
ROSENBERG, MD, Randy M Philadelphia
ROSENBERG, MD, Robin E Philadelphia
ROSENBLATT, MD, Michael Philadelphia
ROSENBLATT, MD, Stanley A Lackawanna
ROSENBLATT, MD, Stanley G Cambria
ROSENBLOOM, MD, Meyer A Allegheny
ROSENBLOOM, MD, Stanley E Allegheny
ROSENBLUM, MD, Benjamin A Philadelphia
ROSENBLUM, MD, Mindy F Philadelphia
ROSENBLUM, MD, Norman G Philadelphia
ROSENBURG, MD, Sidney A Allegheny
ROSENCRANS, MD, David L Allegheny
ROSENFELD, MD, Bernard D Lackawanna
ROSENFELD, MD, Howard Montgomery
ROSENFELD, MD, Jack C Lehigh
ROSENFELD, MD, Jane S Philadelphia
ROSENFELD, MD, Joel C Philadelphia
ROSENFELD, MD, Philip A Montgomery
ROSENFELD, MD, Richard N Montgomery
ROSENFELD, MD, Ronald N Delaware
ROSENMAN, MD, Howard D Bucks
ROSENOW JR, MD, Edward C Philadelphia
ROSENSWEIG, MD, William Luzerne
ROSENTHAL, MD, David E Philadelphia
ROSENTHAL, MD, Richard H Allegheny
ROSENTHAL, MD, Ronald S Montgomery
ROSENTHAL, MD, Stephen I Lackawanna
ROSENWALD, MD, Lindsay A Montgomery
ROSENZWEIG, MD, Abraham H Delaware
ROSENZWEIG, MD, Max Philadelphia
ROSETT, MD, Jeffrey S Philadelphia
ROSIECKI, MD, Michael W Lackawanna
ROSINI, MD, Rita M Allegheny
ROSKA, MD, Jose C Columbia
ROSKO, MD, Thomas J Bucks
ROSNER, MD, Isador K Philadelphia
ROSNER, MD, Michael J Montgomery
ROSS, MD, Abraham Lehigh
ROSS, DO, Harris A Philadelphia
ROSS, MD, John J Philadelphia
ROSS, MD, Martha E Montgomery
ROSS, MD, Patricia E Chester
ROSS, MD, R Douglas Philadelphia
ROSS, MD, Vincent L Lackawanna
ROSSI, MD, John C Allegheny
ROSSI JR, MD, Ralph A Chester
ROSSMAN, MD, Bernard S Philadelphia
ROSSMAN, MD, Max Lehigh
ROST, MD, Charles R Lancaster
ROSTAIN, MD, Anthony L Philadelphia
ROSTOCK, MD, Robert A Lackawanna
ROTENBERG, MD, Larry A Berks
ROTH, MD, Anita W Philadelphia
ROTH, MD, James L Philadelphia
ROTH, DO, Raymond D Montour
ROTH, MD, Russell B Erie
ROTH JR, MD, George R Dauphin
ROTHACKER JR, MD, Gerald W Lancaster
ROTHENBERGER, MD, Marvin K Lehigh
ROTHERMEL, MD, Franklin J Montour
ROTHFUS, MD, William E Allegheny
ROTHKOPF, MD, Brad M Philadelphia
ROTHKOPF, MD, Henry Philadelphia
ROTHMAN, MD, David L Allegheny
ROTHMAN, MD, David L Mercer
ROTHMAN, MD, Maurice M Philadelphia
ROTHMAN, MD, Richard H Philadelphia
ROTHROCK, MD, Gilmore M York
ROTHSCHILD, MD, Jeffrey M Allegheny
ROTHSCHILD, MD, John A Luzerne
ROTHSTEIN, MD, Edward P Bucks
ROTKO, MD, Bernard B Philadelphia
ROTOR, MD, Marilyn L Lancaster
ROTTENBERG, DO, Louis Philadelphia
ROTTSCHAEFER, MD, Bernard L Westmoreland
ROUMM, MD, Alan D Dauphin
ROUSE, MD, Paul V Philadelphia
ROUSE, MD, Steven B Bradford
ROUSSEL, MD, Paula L Dauphin
ROVNER, MD, Harold Philadelphia
ROVNER, Marc S Students
ROVNO, MD, Herbert Philadelphia
ROWAN, MD, Noel M Berks
ROWAN, MD, Paul J Lancaster
ROWAN, MD, Sandra K Berks
ROWE, MD, Lee D Philadelphia
ROWE, MD, Marc I Allegheny
ROWGHANI, MD, Mohammad I Chester
ROWLAND, MD, Edmund B Mercer
ROWLAND, MD, George A Columbia
ROWLAND, MD, Harold A Montgomery
ROWLAND, MD, N Dean Lancaster
ROWLEY, MD, F Lawrence Northampton
ROWLEY, MD, Richard S Chester
ROWMAN, MD, Leo Philadelphia
ROWSHAN, MD, Ghodratollah Northampton
ROXBY, MD, Bruce S Philadelphia
ROY, MD, Robert H Philadelphia
ROYAL, MD, David R Cumberland
ROYAL, MD, Margit E Allegheny
ROYER, MD, Thomas C Montour
ROZANSKI, MD, Stanley J Berks
ROZWADOWSKI, MD, Jack V Erie
RUBEL, MD, Theodor Allegheny
RUBEN, MD, Jerold R Washington
RUBEN, MD, Malcolm E Washington
RUBENFELD, MD, Ira G Philadelphia
RUBENFIELD, MD, Arnold D Allegheny
RUBENSTEIN, MD, David L Philadelphia
RUBENSTEIN, MD, Morton J Dauphin
RUBIN, MD, Alan Philadelphia
RUBIN, DO, Carl S Philadelphia
RUBIN, MD, Emanuel Philadelphia
RUBIN, MD, Harvey M Allegheny
RUBIN, MD, I Edward Philadelphia
RUBIN, MD, Jeffrey W Dauphin
RUBIN, MD, Jeffry F Montgomery
RUBIN, MD, Lore R Allegheny
RUBIN, MD, Marc R Philadelphia
RUBIN, MD, Morton L Dauphin
RUBIN, MD, Myron M Lancaster
RUBIN, MD, Nathan W Montgomery
RUBIN, MD, Peter E Montgomery
RUBIN, MD, Raphael Philadelphia
RUBIN, MD, Richard B Luzerne
RUBIN, MD, Robert F Delaware
RUBIN, MD, S Bruce Philadelphia
RUBINSTEIN, MD, Percy M Philadelphia
RUBIO, MD, Emir W Delaware
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RUBRIGHT, MD, Herbert C Schuylkill
RUBRIGHT JR, MD, Herbert C Schuylkill
RUBY, MD, Edward B Delaware
RUCH, MD, Carl R Northampton
RUDIC, MD, Ernest Philadelphia
RUDICK, MD, Albert J Philadelphia
RUDKIN, MD, Victor M Allegheny
RUDLEY, MD, Lloyd D Philadelphia
RUDNICK, MD, Herman D Philadelphia
RUDNICK, MD, Michael R Philadelphia
RUDNITZKY, MD, Jerome Delaware
RUDOLPH, MD, Joseph Philadelphia
RUDOLPH, MD, Joseph P Allegheny
RUDOLPH, MD, Kenneth H Lackawanna
RUDOLPH, MD, Richard L Bradford
RUDOLPH, MD, Robert I Berks
RUDOLPH JR, MD, Samuel F Montgomery
RUDUSKY, MD, Basil M Luzerne
RUEBEL, MD, Armin A Bucks
RUEBEL, MD, Catherine D Bucks
RUEGER, MD, Raimund G Allegheny
RUEHL, MD, William W Washington
RUETSCHI, MD, Maya S Montour
RUETSCHLIN, MD, James H Philadelphia
RUFE, MD, Redding H Bucks
RUFF, MD, Curtis C Butler
RUFFINI, MD, John A Delaware
RUFFINI, MD, Robert A Delaware
RUFFLE, MD, Joan M Dauphin
RUGART, MD, Karl F Philadelphia
RUGEL, MD, Stanley J Philadelphia
RUGGIERO, DO, Dominic Lackawanna
RUGGIERO, MD, Nicholas J Luzerne
RUGGIERO, MD, Robert A Chester
RUHT, MD, Barry A Lehigh
RUHT, MD, Joseph C Chester
RUIZ, MD, Cesar A Allegheny
RUIZ, MD, Nancy M Philadelphia
RULIN, MD, Marvin C Allegheny
RUMBAUGH, MD, Marshall U Luzerne
RUMBAUGH, MD, Ross S Somerset
RUMBAUGH JR, MD, James O Perry
RUMBLE, MD, Thomas R Allegheny
RUMBLE JR, MD, Charles T Allegheny
RUMPF, MD, Christopher B Monroe
RUMSEY, MD, John L Monroe
RUMSEY, MD, William P Delaware
RUNCO, MD, Angelo S Allegheny
RUNK, MD, Lorenzo G Philadelphia
RUNYAN, DO, John L Columbia
RUNYEON, MD, William K Berks
RUPP, MD, Robert A Fayette
RUPPENTHAL, MD, J Bruce Lackawanna
RUSCHAK, MD, Paul J Allegheny
RUSH, MD, Calvin C Greene
RUSH, MD, George B Beaver
RUSH, MD, John F Fayette
RUSH, MD, Wendy J Lehigh
RUSHFORD, MD, Anthony J Allegheny
RUSIN, MD, Lawrence C Erie
RUSSEK, MD, Edward Dauphin
RUSSELL, MD, Richard L Allegheny
RUSSELL, MD, Richard L Dauphin
RUSSELL JR, MD, Bertram R Chester
RUSSIN, MD, Mary S Union
RUSSIN, MD, Victoria L Philadelphia
RUSSINOVICH, MD, Nicholas A E Allegheny
RUSSMAN, MD, Richard B Allegheny
RUSSO, MD, John F Schuylkill
RUSSO, Marc S Students
RUSSO JR, DO, Anthony P Erie
RUTBERG, MD, Franklin L Philadelphia
RUTBERG, MD, Michael Bucks
RUTENBERG, MD, Harold L Philadelphia
RUTH, MD, D Henry Beaver
RUTH, MD, Thomas K Dauphin
RUTHBERG, MD, Jack Philadelphia
RUTLAND, MD, Hedley E York
RUTT, MD, John M Lancaster
RUTT JR, MD, Clarence H Lancaster
RUTTENBERG, MD, Bertram A Philadelphia
RUTTENBERG, DO, Norman F Philadelphia
RUZBARSKY, MD, Joseph J Lackawanna
RYAN, MD, Charles S Philadelphia
RYAN, MD, Helen M Philadelphia
RYAN, MD, James J Philadelphia
RYAN, MD, John J Northampton
RYAN, MD, Lawrence W Montgomery
RYAN, MD, Timothy M Delaware
RYAN, MD, William C Somerset
RYAN JR, DO, Edward F Philadelphia
RYCHAK, MD, John S Dauphin
RYCKMAN, MD, William F Westmoreland
RYCYNA, MD, James L Allegheny
RYDER JR, MD, Kenneth G Lehigh
RYDZE, MD, Richard A Allegheny
RYDZE, MD, Robert A Allegheny
RYNIER, MD, Donald L Lancaster
RYOO, MD, In O Allegheny
RYSCAVAGE, MD, Edward T Schuylkill

RYSCAVAGE, MD, Thomas S	York

S

SAAVEDRA, MD, Diogenes A	Crawford
SABANAYAGAM, MD, Ponnampalami	Philadelphia
SABATELLE, MD, Robert C	Allegheny
SABBAR, MD, David	Philadelphia
SABEH, MD, George	Allegheny
SABEH, MD, Raif K	Allegheny
SABLE, Carole A	Students
SABOKBAR, MD, Nasser	Montgomery
SABOL, MD, John B	Cumberland
SABOL, MD, Louise J	Montour
SABUGO, MD, Evelyn F	Philadelphia
SACCHETTI, MD, Alfred D	Philadelphia
SACCO, Margaret M	Students
SACCO, MD, Russell J	Allegheny
SACHAKUL, MD, Chitrinee	Westmoreland
SACHAROK, Cynthia A	Students
SACHDEV, MD, Ranjan	Northampton
SACHDEVA, MD, Ajit K	Philadelphia
SACHDEVA, MD, Ravindra K	Mercer
SACHS, MD, Jonathan R	Philadelphia
SACHS, MD, Marvin L	Philadelphia
SACHS, MD, Murray	Allegheny
SACKETT, MD, Charles F	Philadelphia
SACKHEIM, MD, Robert	Bucks
SACKS, MD, Charles L	Philadelphia
SACKS, MD, Richard P	Lebanon
SACKS, DO, Stephen E	Montgomery
SADEKNI, MD, Marwan E	Westmoreland
SADEL, Scott M	Students
SADLER, MD, John M	Allegheny
SADOFF, MD, Robert L	Montgomery
SADOWSKI, MD, Hubert F	Allegheny
SADR, MD, Farrokh S	Lehigh
SAFDAR-ALI, MD, Mohammad	Schuylkill
SAFIER, MD, Joel	Allegheny
SAFLEY, MD, Max W	Indiana
SAG, MD, Jerome E	Montgomery
SAGEN, MD, William	Bucks
SAGER, MD, Ethel	Philadelphia
SAGHAFI, MD, Darius	Westmoreland
SAGIN, MD, Todd	Philadelphia
SAHAI, MD, Ashok K	Washington
SAHILLIOGLU, MD, Refik	Luzerne
SAHL, MD, Henry G	Philadelphia
SAHLANEY, MD, William J	Cambria
SAHOO, MD, Dillswar	Schuylkill
SAHOO, MD, Kashi Nath	Berks
SAHOVEY, MD, James R	Allegheny
SAIDMAN, MD, Lester M	Luzerne
SAIFEE, MD, Kutub M	Allegheny
SAIONTZ, MD, Howard I	Cambria
SAKKAL, MD, Saad	Mercer
SALA, MD, Luis E	Philadelphia
SALAK, MD, Wasyl W	Philadelphia
SALAM, MD, Mahi	Chester
SALAND, MD, David K	Delaware
SALANON, MD, Paul	Philadelphia
SALARI-LAK, MD, Farhad	Indiana
SALAS, MD, Andre C J	Allegheny
SALATKA, MD, Karl W	Westmoreland
SALAZAR, MD, Edgardo P	Carbon
SALAZAR, MD, Pedro A	Luzerne
SALCEDO, MD, Wilfredo G	Northampton
SALDANA, MD, Idel J	Jefferson
SALEEM, MD, Mohammad A	Lackawanna
SALEH, MD, Ahmab N	Philadelphia
SALERNO, MD, Francis A	Berks
SALERNO, MD, Sal J	Cambria
SALES, MD, Irving J	Philadelphia
SALES, MD, Phoenix M	Philadelphia
SALGADO, MD, Edward M	Northampton
SALIM, MD, Bozorgmehr	Delaware
SALINDONG, MD, Jaime P	Montgomery
SALKIND, MD, Gary D	Delaware
SALKO, MD, Gregory J	Lackawanna
SALLASH JR, MD, Robert J	Northampton
SALLER JR, MD, Devereux N	Berks
SALMERON, MD, Geraldine	Philadelphia
SALMON, MD, James H	Erie
SALNER, MD, Nathan P	Philadelphia
SALVATORE, MD, Michael A	Lycoming
SALVATORE, MD, Michael R	Erie
SALVO, MD, Paul J	Philadelphia
SALVOZA, MD, Manuel I	Allegheny
SALYARD, MD, Lann B	Philadelphia
SAMAD, MD, Mohammad A	Northumberland
SAMADANI, MD, Siroos R	Allegheny
SAMAHA, MD, Richard G	Montour
SAMARASINGHE, MD, Gunasiri	Erie
SAMELSON, MD, Leo	York
SAMENT, MD, Sidney	Northampton
SAMET, MD, Sherwood L	Monroe
SAMII, MD, Abdol H	Luzerne
SAMII, MD, Ali M	Cambria
SAMITZ, MD, M Harriss	Philadelphia
SAMPATH, MD, Krishna	Philadelphia
SAMPATHACHAR, MD, Kakkadasam R	Philadelphia
SAMPSON, MD, David A	Philadelphia
SAMSON, MD, Bienvenido T	Philadelphia
SAMUELSON, MD, Joel S	Monroe
SANCHEZ, MD, Blanca S	Philadelphia
SANDBERG, MD, James A	Lehigh
SANDBERG, MD, Theodore E	Allegheny
SANDEL, MD, Mary E	Philadelphia
SANDERS, MD, Francis A	Philadelphia
SANDERS, MD, Robert E	Westmoreland
SANDERSON, MD, Douglas K	Dauphin
SANDERSON, MD, Vincent A	Mercer
SANDHAUS, MD, Julius L	Lancaster
SANDHU, MD, Rajinder S	Allegheny
SANDLER, MD, Kenneth R	Chester
SANDLER, MD, Richard	Blair
SANDO, MD, Ralph S	Philadelphia
SANDOVAL, MD, Conchita Q	Westmoreland
SANDS, MD, Jeffrey J	Luzerne
SANDS, MD, S David	Luzerne
SANDSON, MD, Gerald B	Allegheny
SANDSTROM, MD, Paul H	Erie
SANDSTROM JR, MD, Frank T	Montgomery
SANFORD, MD, Frederic E	Lycoming
SANFORD, MD, Robert G	Dauphin
SANFORD, MD, Robert S	Tioga
SANGHI, MD, Jodh K	Warren
SANGILLO, MD, Mario M	Dauphin
SANGRUJEE, MD, Kannika L	Allegheny
SANGRUJEE, MD, Weerasak	Allegheny
SANKAR, MD, Naganathan S	Beaver
SANKARAN, MD, Manickam	Blair
SANKARI, MD, Muhammed A	Mckean
SANKEY, Heather Z	Students
SANNER, MD, John C	Lackawanna
SANNER JR, MD, Edgar G	Allegheny
SANPEDRO, MD, Floro D	Philadelphia
SANSONE, MD, Thomas C	Montgomery
SANSTEAD, MD, John K	York
SANT RAM, MD, Deepak	Chester
SANTAMARIA, MD, Frank R	Westmoreland
SANTANGELO, Kathylee	Students
SANTEN, MD, Richard J	Dauphin
SANTILLAN, MD, Victor H	Blair
SANTILLI, MD, Thomas F	Philadelphia
SANTINI, MD, Lewis C	Montour
SANTO, MD, Jean L	Lehigh
SANTOMENNA, MD, Michael A	Erie
SANTOPOLO, MD, Anthony C	Delaware
SANTORA, MD, Robert A	Crawford
SANTORA JR, MD, Frank J	Allegheny
SANTORE, MD, Felice J	Delaware
SANTORE, MD, Louis X	Montgomery
SANTORO, MD, Jerome	Philadelphia
SANTOS, MD, Arthur M	Allegheny
SANTOS, MD, Cesar R	Lawrence
SANTOS, MD, Rodolfo R	Somerset
SANTOSO, MD, Limjadi	Erie
SANTOYO-STEIN, MD, Maria C	Philadelphia
SAPIRSTEIN, MD, Wolf	Dauphin
SAQUIN, MD, Raineldo C	Mckean
SARACCO, MD, Thomas R	Allegheny
SARACHEK, MD, Norman S	Lehigh
SARADAR, MD, Riad	Fayette
SARAIN, MD, Antonio N	Crawford
SARAJEDINI, MD, Hossain	Mckean
SARAN, MD, Madhukar	Susquehanna
SARAS, MD, Peter L	Luzerne
SARAVITZ JR, Eugene M	Students
SARDESAI, MD, Prabhaker G	Erie
SARIEGO, MD, Joaquin	Philadelphia
SARIN, MD, Lov K	Philadelphia
SARIS, MD, Anne L	Montgomery
SARIS, MD, Demetrius S	Montgomery
SARKER, MD, Chitta R	Montgomery
SARKER, MD, Muhammad A R	Berks
SARMA, MD, Akkaraju V N	Philadelphia
SARNER, MD, Joel B	Allegheny
SARNOWSKI, MD, Robert J	Lackawanna
SARSHIK, MD, Milton	Philadelphia
SARSHIK, MD, Stuart A	Philadelphia
SARUBIN, MD, Daniel R	Lehigh
SARUK, MD, Michael L	Philadelphia
SARVER, MD, Ray G	Westmoreland
SARVER, MD, Robert O	Allegheny
SASS, MD, Robert E	Mercer
SASSANI, MD, Joseph W	Dauphin
SASSON, MD, Robert	Bucks
SASTRY, MD, Dasika M	Montgomery
SATALOFF, MD, Dahlia M	Philadelphia
SATALOFF, MD, Joseph	Philadelphia
SATALOFF, MD, Robert T	Philadelphia
SATARIANO, MD, Daniel W	Philadelphia
SATINSKY, MD, Jonathan D	Delaware
SATTEL, MD, Andrew B	Philadelphia
SATTILARO, MD, Anthony J	Philadelphia
SAUCERMAN, MD, Shirley A	Warren
SAUCO, MD, M Concepcion	Philadelphia
SAUER, MD, Dieter	Westmoreland
SAUER, MD, Thomas S	Northampton
SAUERS, MD, Patricia L	York
SAUERTIEG, MD, Elliott A	Dauphin
SAUL, MD, Albert	Philadelphia
SAUL, MD, Leon J	Philadelphia
SAUL, MD, Richard B	Philadelphia
SAUL, MD, Robert F	Montour
SAUL, MD, Robert W	Allegheny
SAULL, MD, Sondra C	Philadelphia
SAUNDERS, MD, Celeste M	Philadelphia
SAUNDERS, MD, Charles D	Northampton
SAUNDERSON JR, MD, Robert W	Lancaster
SAUSSER, MD, Eugene W	Mifflin/Juniata
SAVACOOL, MD, Jacob W	Philadelphia
SAVAGE, MD, Donald J	Luzerne
SAVAGE, MD, Michael P	Philadelphia
SAVAGE, MD, Peter J	Luzerne
SAVARESE, MD, Ronald P	Philadelphia
SAVINO, MD, Peter J	Philadelphia
SAVORY, MD, William J	Dauphin
SAWARDEKAR, MD, Arun S	Mercer
SAWARDEKAR, MD, Shubhada A	Mercer
SAWKO, Darlene C	Allegheny
SAXENA, MD, Varun	Bucks
SAXON, MD, Joseph G	Dauphin
SAYE JR, MD, William H	Dauphin
SAYEN, MD, John J	Philadelphia
SAYERS, MD, Francis P	Northumberland
SAYERS, MD, Kenneth H	Indiana
SAYLOR, MD, Randall M	Butler
SAYLOR, MD, Richard F	Montgomery
SAYRE, MD, Michael R	Allegheny
SAYSON, MD, Jose N	Lebanon
SCAGLIOTTI, MD, Charles J	Lehigh
SCARAMUCCI, MD, John C	Allegheny
SCARANO, MD, Domenico	Luzerne
SCARF, MD, Maxwell	Philadelphia
SCAROLA, MD, Joseph A	Montgomery
SCARPA, MD, Harry C	Montgomery
SCARPINO, MD, Leo J	Lehigh
SCARSELLATO, MD, John N	Allegheny
SCERBO, MD, James A	Jefferson
SCHAAF, MD, John T	Erie
SCHACHTER, MD, Allan B	Allegheny
SCHACHTER, MD, Joseph	Allegheny
SCHACHTERLE, MD, Ralph E	Lancaster
SCHADE, MD, John F	Luzerne
SCHADT, MD, Daniel C	Northampton
SCHADT JR, MD, Oliver S	Lehigh
SCHAEBLER, MD, M Lee	Berks
SCHAEFER, MD, C Russell	Allegheny
SCHAEFER, MD, Thomas J	Cambria
SCHAEFFER, MD, Frances C	Lehigh
SCHAEFFER, MD, William A	Lancaster
SCHAEFFER JR, MD, William E	Lebanon
SCHAEFGEN, MD, Madalyn	Lehigh
SCHAFER JR, MD, Francis J	Allegheny
SCHAFFER, MD, Burton	Philadelphia
SCHAFFER, MD, David B	Philadelphia
SCHAFFER, MD, David N	Dauphin
SCHAFFER, MD, David W	Philadelphia
SCHAFFER, MD, Jonathan L	Philadelphia
SCHAFFER, MD, Scott R	Philadelphia
SCHAFFER, MD, Sonja G	York
SCHAFFER, MD, Ted C	Allegheny
SCHAFFNER, Kenneth F	Allegheny
SCHAFFNER, MD, Meade D	Lancaster
SCHAFFZIN, MD, Lawrence	Philadelphia
SCHAITKIN, MD, Barry M	Dauphin
SCHALL, MD, Roy F	Allegheny
SCHALLER, MD, James A	Delaware
SCHAMP, MD, Richard O	Jefferson
SCHANER, MD, Paul J	Allegheny
SCHANTZ, MD, John C	Lancaster
SCHANZER, MD, Harriet	Philadelphia
SCHAPIRA, MD, Daniel	Lackawanna
SCHAPIRO, MD, Rolf L	Allegheny
SCHARLE, MD, W Timothy	Northampton
SCHARTEL, DO, Albert P	Berks
SCHATANOFF, MD, David	Philadelphia
SCHATANOFF, MD, Joseph	Philadelphia
SCHATTNER, MD, Allen S	Allegheny
SCHATZ, MD, Norman J	Philadelphia
SCHAUB, MD, David H	Allegheny
SCHAUBLE, MD, Thomas L	Allegheny
SCHECTER, MD, Benjamin C	Mckean
SCHEER, MD, R Scott	Chester
SCHEERS, MD, George F	Luzerne
SCHEFF, MD, Alice M	Berks
SCHEID JR, MD, John E	Westmoreland
SCHEIE, MD, Harold G	Philadelphia
SCHEIN, MD, Alan L	Dauphin
SCHEIN, MD, Robert A	Allegheny
SCHEIN II, MD, George	Allegheny
SCHEINER, Robin B	Students
SCHEINFELDT, DO, Barton D	Philadelphia
SCHEINMAN, MD, Harold Z	Allegheny
SCHELL, MD, Gary F	Centre
SCHELL, MD, Stephen E	Erie
SCHELL JR, MD, Francis J	Wyoming
SCHENCK, MD, Paul H	Lehigh
SCHENFELD, MD, Louis A	Cambria
SCHENKEL, MD, Eric J	Northampton
SCHERER, MD, Bernard C	Indiana
SCHERER, DO, Jerome E	Allegheny
SCHERR, Roberta L	Students
SCHERR, MD, Stuart A	Philadelphia
SCHEUER, MD, John W	Lackawanna
SCHEUERMAN, DO, Thomas J	Philadelphia
SCHEUERMANN, MD, Henry A	Delaware
SCHEUERMANN, MD, Richard E	Philadelphia
SCHIELE JR, MD, Herbert S	Philadelphia
SCHIETROMA, MD, Cindy J	Dauphin
SCHIFALACQUA, MD, Philip A	Philadelphia
SCHIFF, MD, Melvin M	Allegheny
SCHILLER, MD, Harvey J	Cambria
SCHILLER, MD, Herbert M	Philadelphia
SCHILLER, MD, Ruth P	Bucks
SCHILLI, MD, Rudolph	Cambria
SCHIMERT, MD, Arnd P	Philadelphia
SCHIMMEL, MD, Martin	Philadelphia
SCHIMMEL, MD, Nelson H	Philadelphia
SCHIMMER, MD, Barry M	Philadelphia
SCHINDLER, MD, Peter D	Chester
SCHINFELD, MD, Louis H	Montgomery
SCHIOWITZ, MD, Albert	Luzerne
SCHIOWITZ, MD, Mark F	Luzerne
SCHIRK, MD, Steven K	Montour
SCHIRO, MD, John C	Dauphin
SCHLABACH, MD, Donald M	Erie
SCHLACKMAN, MD, Neil	Bucks
SCHLAFF, MD, Lillian T	Philadelphia
SCHLAGER, MD, Barbara A	Philadelphia
SCHLAGER, MD, Charles E	York
SCHLANSKY, MD, Ronald M	Cumberland
SCHLEIFER, MD, Charles R	Philadelphia
SCHLESINGER, MD, Sam	Luzerne
SCHLESS, MD, Arthur P	Chester
SCHLESS, MD, Guy L	Philadelphia
SCHLESSEL, MD, Richard B	Philadelphia
SCHLESSINGER, David A	Allegheny
SCHLEZINGER, MD, Nathan S	Philadelphia
SCHLITZER, MD, William H	Schuylkill
SCHLOSSBERG, MD, David	Philadelphia
SCHLOSSBERG, MD, Michael A	Allegheny
SCHLOSSER, MD, David E	Lancaster
SCHMELTZ, MD, Ralph	Allegheny
SCHMIDHOFER, MD, Mark	Allegheny
SCHMIDT, MD, Arnold P	Luzerne
SCHMIDT, MD, H William	Montgomery
SCHMIDT, MD, Robert J	Elk/Cameron
SCHMIDT JR, MD, Erwin R	Philadelphia
SCHMIELER, MD, George C	Washington
SCHMIELER, MD, George P	Washington
SCHMITT, MD, Albrecht	Philadelphia
SCHMITT, MD, Charles L	Allegheny
SCHMITT, MD, Herman L	Allegheny
SCHMITT, Scott A	Allegheny
SCHMUKLER, DO, Anita G	Philadelphia
SCHMUTZLER III, MD, Robert C	Montgomery
SCHNALL, MD, Barry	Philadelphia
SCHNALL, SMD, Charles	Philadelphia
SCHNALL, MD, David J	Philadelphia
SCHNALL, MD, Nathan	Philadelphia
SCHNARRS, MD, Robert H	Allegheny
SCHNAUFER, MD, Louise	Philadelphia
SCHNEEBERG, MD, Arthur L	Philadelphia
SCHNEEBERG, MD, J Myron	Philadelphia
SCHNEEBERG, MD, Norman G	Philadelphia
SCHNEIDER, MD, Bernard	Philadelphia
SCHNEIDER, MD, Chester L	Montgomery
SCHNEIDER, MD, Jan	Philadelphia
SCHNEIDER, MD, Jill	Philadelphia
SCHNEIDER, MD, John A	Allegheny
SCHNEIDER, MD, Lawrence H	Philadelphia
SCHNEIDER, MD, Richard R	Allegheny
SCHNEIDER, MD, Robert E	Allegheny
SCHNEIDER, MD, Roberta L	Montgomery
SCHNEIDER JR, MD, Henry C	Montgomery
SCHNEIMAN, MD, Maurice H	Philadelphia
SCHNITZLER, MD, Joseph	Northampton
SCHNURER, MD, Charles I	Allegheny
SCHOCK, MD, William W	Huntingdon
SCHOCKER, MD, Jack D	Blair
SCHOENFELD, MD, Clyde D	Allegheny
SCHOEPPNER, MD, Eric	Northampton
SCHOFIELD, MD, Richard A	Montgomery
SCHOLL, MD, Harvey W	Montgomery
SCHOLL JR, MD, Harvey W	Bucks
SCHOLLAERT, MD, Richard A	Allegheny
SCHONAUER, MD, Thomas D	York
SCHONFELD, MD, David J	Philadelphia
SCHOOLEY, MD, Frank B	Luzerne
SCHOOLWERTH, MD, Anton C	Dauphin
SCHOPFER, MD, Ralph E	Lycoming
SCHOTT JR, MD, Clifford E	Philadelphia
SCHOWALTER, MD, Donald R	Westmoreland
SCHRADING, Walter A	Allegheny
SCHRAGGER, MD, Alan H	Lehigh
SCHRAMM, MD, Frank E	Northampton
SCHRAMM JR, MD, Victor L	Allegheny
SCHRECK, MD, Fred M	Northumberland
SCHRECKENGAUST, MD, Robert H	Lackawanna
SCHREIBER, MD, Richard	Dauphin
SCHREIBER, MD, Richard D	Lebanon
SCHREINER, MD, Glenwood R	Luzerne
SCHRENZEL, MD, Steven	Delaware
SCHROCK, MD, Jon H	Lancaster
SCHROCK, MD, Laura J	Cambria
SCHROFF JR, Richard L	Students
SCHUBART, MD, George R	Delaware
SCHUBERT, MD, John J	Lancaster
SCHUCHERT, Barbara A	Allegheny
SCHUCKER, MD, Forrest A	Dauphin
SCHUERCH, MD, Conrad	Montour
SCHUESSLER, MD, Paul W	Northampton
SCHULHOFF, MD, John W	Allegheny
SCHULLER, MD, Diane E	Montour
SCHULMAN, MD, Benjamin L	Allegheny
SCHULMAN, MD, Edward S	Philadelphia
SCHULMAN, MD, Norman	Luzerne
SCHULTHEIS JR, MD, Carl F	Montgomery
SCHULTZ, MD, Adrienne J	Jefferson
SCHULTZ, MD, Edward D	Blair
SCHULTZ, MD, Edward J	Blair
SCHULTZ, MD, Edward M	Allegheny
SCHULTZ, MD, Jeffrey C	Allegheny
SCHULTZ, MD, Julius	Philadelphia
SCHULTZ, MD, Kenneth E	Dauphin
SCHULTZ, MD, Theodore A	Westmoreland
SCHULZ, MD, August J	Lancaster
SCHULZ, MD, Jacob A	Lancaster
SCHUMACHER, DO, Carol M	Allegheny
SCHUMACHER, MD, L Richard	Montgomery

SCHUMAN, MD, Robert A	Lackawanna
SCHUSTER, MD, Albert H	Philadelphia
SCHUSTER, MD, James L	Erie
SCHWAB, MD, Morton E	Philadelphia
SCHWAB, MD, Richard J	Philadelphia
SCHWAB, MD, Robert H	Philadelphia
SCHWAGER, MD, Mark I	Philadelphia
SCHWALB, MD, Allen J	Philadelphia
SCHWARCZ, MD, Harriet B	Montgomery
SCHWARTZ, MD, Albert M	Philadelphia
SCHWARTZ, MD, Alec R	Allegheny
SCHWARTZ, MD, Allan B	Philadelphia
SCHWARTZ, MD, Andrew E	Philadelphia
SCHWARTZ, MD, Barry J	Philadelphia
SCHWARTZ, MD, Bennett K	Philadelphia
SCHWARTZ, MD, Bradford B	York
SCHWARTZ, MD, Daniel N	Allegheny
SCHWARTZ, MD, Donald S	Chester
SCHWARTZ, MD, Edward	Delaware
SCHWARTZ, MD, Emanuel E	Philadelphia
SCHWARTZ, MD, Gordon F	Philadelphia
SCHWARTZ, MD, Heinz G	Philadelphia
SCHWARTZ, MD, Henry J	Allegheny
SCHWARTZ, MD, Ira	Schuylkill
SCHWARTZ, MD, Irving R	Philadelphia
SCHWARTZ, MD, Jan A	Montour
SCHWARTZ, MD, Joel D	Allegheny
SCHWARTZ, MD, Joel L	Montgomery
SCHWARTZ, MD, Jonathan	Westmoreland
SCHWARTZ, MD, Joshua J	Philadelphia
SCHWARTZ, MD, Laurence M	Philadelphia
SCHWARTZ, MD, Leonard	Allegheny
SCHWARTZ, MD, Louis	Philadelphia
SCHWARTZ, MD, Louis W	Montgomery
SCHWARTZ, MD, Marc L	Philadelphia
SCHWARTZ, MD, Melvin H	Berks
SCHWARTZ, MD, Michael L	Allegheny
SCHWARTZ, MD, Milton A	Bucks
SCHWARTZ, MD, Peter L	Bucks
SCHWARTZ, MD, Raymond	Philadelphia
SCHWARTZ, MD, Reuben B	Philadelphia
SCHWARTZ, MD, Robert P	Philadelphia
SCHWARTZ, MD, Sheldon M	Lycoming
SCHWARTZ, MD, Stephen L	Philadelphia
SCHWARTZMAN, MD, Robert J	Philadelphia
SCHWARZ, MD, Gabriel A	Philadelphia
SCHWARZSCHILD, MD, Walter	Philadelphia
SCHWEGMAN, MD, Cletus W	Philadelphia
SCHWEIKLE, MD, Mary R	Lycoming
SCHWEITZER, MD, Jane G	Philadelphia
SCHWEITZER, MD, William J	Allegheny
SCHWEIZER, MD, Robert R	Berks
SCHWENDEMAN, MD, David L	Northampton
SCHWENTKER, MD, Edward P	Dauphin
SCHWERHA, MD, Joseph J	Allegheny
SCHWERIN, MD, William F	Allegheny
SCHWINGE, MD, Elaine A	Lehigh
SCHWITER, MD, E Joseph	Luzerne
SCIALDONE, MD, Anthony M	Allegheny
SCIALLA, MD, Salvatore J	Lackawanna
SCIARA, MD, Christine	Chester
SCIBAL, MD, Gary J	Lancaster
SCIBETTA, MD, Mario P	Erie
SICCHITANO, MD, David C	Northumberland
SICCHITANO, MD, Leon P	Schuylkill
SICIUTELLA, MD, Leonard J	Delaware
SCIOSCIA, MD, Eugene A	Allegheny
SCIPIONE, MD, C Richard	Philadelphia
SCIULLI, MD, Robert L	Allegheny
SCIULLO, MD, Vincent F	Philadelphia
SCOGLIETTI, MD, Vincent C	Allegheny
SCOGNA, MD, Joseph E	Philadelphia
SCOLES, MD, Karen S	Philadelphia
SCOPELLITI, MD, Joseph A	Bradford
SCORNAVACCHI, MD, Joseph M	Berks
SCORNAVACCHI JR, MD, Joseph M	Berks
SCOTT, MD, Alvin J	Luzerne
SCOTT, MD, Dorothy C	Allegheny
SCOTT, MD, Durelle T	Luzerne
SCOTT, MD, Earl S	Philadelphia
SCOTT, MD, Henry	Philadelphia
SCOTT, MD, J Clifford	Chester
SCOTT, MD, Jack A	Allegheny
SCOTT, MD, John H	Allegheny
SCOTT, MD, Kincy J	Indiana
SCOTT, DO, Mark E	Delaware
SCOTT, MD, Norman E	Allegheny
SCOTT, DO, Robert C	Lancaster
SCOTT JR, MD, Samuel D	Philadelphia
SCOTTI, MD, Daniel M	Philadelphia
SCOTTI, MD, Louis N	Allegheny
SCOVAZZO, MD, Mary L	Allegheny
SCROBOLA, MD, Charles C	Luzerne
SCROSCIA, Paul J	Allegheny
SCUDERI, MD, Steven A	Philadelphia
SCULLIN III, MD, John P	Mercer
SCULLY, MD, Dennis M	Erie
SCULLY, MD, John P	Berks
SEARFOSS, MD, Roger C	Westmoreland
SEARS, MD, Alan J	Philadelphia
SEARS, MD, Henry F	Philadelphia
SEBASTIAN, MD, Eugene F	Dauphin
SEBASTIANELLI, MD, Mario J	Lackawanna
SEBOK, MD, Marianne	Philadelphia
SECHLER, MD, Edith W	Venango
SECKINGER, MD, Raymond P	Lehigh
SECUNDA, MD, Steven K	Delaware
SEDA, MD, Hector J	Berks
SEDACCA, MD, Paul J	Philadelphia
SEEBER, MD, John J	Cambria
SEECOF, MD, Richard M	Allegheny
SEELAUS, MD, Jere F	Montgomery
SEGAL, MD, Allan	Beaver
SEGAL, MD, Arthur M	Lackawanna
SEGAL, MD, Bernard L	Philadelphia
SEGAL, MD, Hyman I	Philadelphia
SEGAL, MD, Louis	Philadelphia
SEGAL, MD, Ricardo	Allegheny
SEGEL, MD, David P	Allegheny
SEGRAVE-DALY, MD, Stephen L	Philadelphia
SEGU, MD, Subramanyam	Erie
SEHGAL, MD, Kuldeep	Beaver
SEIAVITCH, MD, Samuel A	Allegheny
SEIDEL, MD, Eric C	Berks
SEIDEL, MD, Horace Y	Northampton
SEIDL, MD, Daniel C	York
SEIDLER, MD, Eleanor E	Montgomery
SEIDLICH, MD, Franklin T	Dauphin
SEIDNER, MD, Michael R	Montgomery
SEIFERT, MD, George L	Philadelphia
SEIFERT, MD, Thomas E	Cambria
SEIFERTH, MD, William J	Erie
SEIFFERT, MD, Thomas E	Allegheny
SEIGLE, MD, Walter E	Lackawanna
SEINIGE, MD, Ursula L	Philadelphia
SEIPLE, MD, Harvey H	Lancaster
SEITCHIK, MD, Murray W	Philadelphia
SEITZ, MD, Edward R	Allegheny
SEITZ, MD, Nevin H	York
SEKARAN, MD, Kamalesh K	Butler
SEKARAN, MD, Somasundaram K	Butler
SEKHAR, MD, Laligam N	Allegheny
SELBY, MD, Charles L	Montgomery
SELBY, MD, Theodore	Montgomery
SELEDNIK, MD, Leonard J	Allegheny
SELHAT, MD, George F	Philadelphia
SELICKMAN, MD, Mitchell A	Philadelphia
SELIGER, MD, Gustav	Delaware
SELINGER, MD, Howard A	Philadelphia
SELKER, MD, Robert G	Allegheny
SELKOVITS, MD, Sidney	Allegheny
SELLER, MD, Michael S	Philadelphia
SELLERS, MD, Alfred M	Philadelphia
SELLERS, MD, Robert W	Berks
SELLERS JR, MD, Thomas D	Montour
SELSMAN, MD, Joseph V	Montgomery
SELTMAN, MD, Martin	Allegheny
SELTZER, MD, Benjamin	Philadelphia
SELTZER, MD, Harry	Allegheny
SELTZER, MD, Joseph L	Philadelphia
SELTZER, MD, Maurice	Philadelphia
SELTZER, MD, William I	Allegheny
SEMBROT, MD, William B	Philadelphia
SEMINS, MD, Howard	Allegheny
SEMPLE, MD, Joseph M	Erie
SENA, MD, Frank W	Philadelphia
SENAN, MD, Pushpendra	Allegheny
SENDZIK, MD, Nestor I	Bucks
SENIOW, MD, Raymond V	Lawrence
SENITA, MD, G Robert	Allegheny
SENTER, MD, Howard J	Allegheny
SEO, MD, Jin S	Berks
SERAFY, MD, Michael M	Allegheny
SERBER, MD, William	Philadelphia
SERENE, MD, Harry E	Allegheny
SERFAS, MD, Lee S	Northampton
SERGIE, MD, Aly	Potter
SERINE, MD, Enrico A	Lackawanna
SEROSKA, MD, Phillip J	Luzerne
SEROTA, MD, Fredric T	Philadelphia
SERVOSS, MD, Spencer J	Lycoming
SERWINT, MD, Michael S	Venango
SESSION, MD, William C	Allegheny
SESSIONS, Scott C	Students
SETH, MD, Prabhat	Allegheny
SETH, MD, Rajendra N	Philadelphia
SETHBHAKDI, MD, Somkiat	Philadelphia
SETHI, MD, Surendra K	Butler
SETTY, MD, Polepalli S	Westmoreland
SEVICK, MD, Myron E	Centre
SEVIN, MD, Elizabeth G	Philadelphia
SEWAK, MD, Michael E	Cambria
SEWELL, MD, William H	Bradford
SEXAUER, MD, William P	Philadelphia
SEXTON JR, MD, George L	Berks
SEY, MD, Mark J	Philadelphia
SEYFRIED, Donald M	Students
SEYLER, MD, Raymond Q	Delaware
SEYMOUR, MD, Parker M	Philadelphia
SGARLAT, MD, Joseph R	Luzerne
SGRO, MD, Antonio	Philadelphia
SHABER, MD, Gary S	Philadelphia
SHACKLEFORD, MD, Robert E	Montgomery
SHACKLETT, MD, Dorothy E	Philadelphia
SHADLE, MD, Chester A	York
SHAEFFER, MD, Joseph M	Bucks
SHAFER, MD, Edward A	Luzerne
SHAFFER, MD, Carolyn W	Dauphin
SHAFFER, MD, Donald Y	Beaver
SHAFFER, MD, Eugene M	Berks
SHAFFER, MD, George W	Bucks
SHAFFER, MD, Howard L	Lawrence
SHAFFER, MD, Irvin G	Berks
SHAFFER, MD, Lawrence J	Dauphin
SHAFFER, MD, Walter L	Allegheny
SHAFIA, MD, Hass	Philadelphia
SHAFIQUE, MD, Mohammad	Lycoming
SHAH, MD, Ghazanfar A	Westmoreland
SHAH, MD, Gopaldas V	Cambria
SHAH, MD, Harnish V	Berks
SHAH, MD, Jaykumar H	Bucks
SHAH, MD, Jitendra N	Philadelphia
SHAH, MD, Jyotindra T	Allegheny
SHAH, MD, Kokila D	Philadelphia
SHAH, MD, Mahendra K	Susquehanna
SHAH, MD, Manjula S	Jefferson
SHAH, MD, Mubarik A	Philadelphia
SHAH, MD, Mukesh V	Allegheny
SHAH, MD, Narayan	Montour
SHAH, MD, Rahmat	Lackawanna
SHAH, MD, Ranjan R	Delaware
SHAH, MD, Ranjit R	Delaware
SHAH, MD, Ratan S	Westmoreland
SHAH, MD, Shirish N	Jefferson
SHAH, MD, Shirish N	Allegheny
SHAH, MD, Syed G	Schuylkill
SHAH, MD, Vijaya J	Bucks
SHAHEEN, MD, Robert G	Blair
SHAHINFAR, MD, Shahnaz	Delaware
SHAIKH, MD, Aftab A	Lackawanna
SHAIKH, MD, Mohammed N	Westmoreland
SHAMAI, MD, Haroun A	Lehigh
SHAMBLIN, MD, Jerry D	Allegheny
SHAMIMI-NOORI, MD, Soroush	Dauphin
SHAMPAIN, MD, Mark P	Lehigh
SHANAHAN, MD, J Rush	Philadelphia
SHANAHAN, MD, Nancy R	Bucks
SHANDER, MD, Ernest G	Lackawanna
SHANK, MD, Irene A	Allegheny
SHANKAR, MD, Ram G	Bucks
SHANKAR, MD, V S	Philadelphia
SHANMUGAM, MD, Kasinathan	Northampton
SHANNON, MD, Robert E	Dauphin
SHAPERA, MD, Richard P	Allegheny
SHAPIRA, MD, Edith L	Allegheny
SHAPIRO, MD, Alvin P	Allegheny
SHAPIRO, MD, Bernard	Philadelphia
SHAPIRO, DO, Bertram P	Philadelphia
SHAPIRO, MD, Charles J	Franklin
SHAPIRO, MD, Harvey H	Franklin
SHAPIRO, MD, Jacob	Philadelphia
SHAPIRO, MD, John A	Berks
SHAPIRO, MD, Leonard H	Philadelphia
SHAPIRO, MD, Lester F	Allegheny
SHAPIRO, Mark H	Allegheny
SHAPIRO, MD, Morry	Allegheny
SHAPIRO, MD, Richard P	Philadelphia
SHAPIRO, MD, Samuel S	Philadelphia
SHAPIRO, MD, Stuart G	Venango
SHAPIRO, MD, Stuart H	Philadelphia
SHARBAUGH, MD, Donald G	Cambria
SHARER, DO, Carl W	Delaware
SHARIAT, MD, Iraj	Somerset
SHARIFF, MD, Haji M	Philadelphia
SHARIFI-AZAD, MD, Said	Philadelphia
SHARKEY, MD, Thomas G	Luzerne
SHARMA, MD, Amar J	Northampton
SHARMA, MD, Jashwant K	Westmoreland
SHARMA, MD, Kusum	Westmoreland
SHARMA, MD, Meera V	Lackawanna
SHARMA, MD, Om P	Northampton
SHARMA, MD, Raj K	Delaware
SHARMA, MD, Sukh D	Erie
SHARMA, MD, Usha	Allegheny
SHARMAN, MD, Michael H	Washington
SHARP, MD, Ira R	Philadelphia
SHARPLES, MD, Wynne	Philadelphia
SHARPLESS, MD, Edwin D	Delaware
SHARPS, MD, Frank	Philadelphia
SHARRA, William G	Allegheny
SHARRAR, MD, Karen E	Philadelphia
SHARRAR, MD, Robert G	Philadelphia
SHARRER, MD, Margaret C	Allegheny
SHASHIKUMAR, MD, V L	Philadelphia
SHATTEN, MD, Thomas A	Allegheny
SHATZ, MD, Eugene M	Potter
SHATZ, Matthew J	Allegheny
SHAUB, MD, Paul D	York
SHAUB JR, MD, Howard G	Blair
SHAUGHNESSY, MD, Michael J	Allegheny
SHAVER, MD, John C	Allegheny
SHAVER, MD, Verne C	Allegheny
SHAW, DO, Donald D	Tioga
SHAW, MD, Gordon A	Lycoming
SHAW, MD, James A	Dauphin
SHAW, MD, John L	Montgomery
SHAWALUK, MD, Paul D	Philadelphia
SHAY, MD, Paul L	Allegheny
SHAY, MD, Robert J	Philadelphia
SHEA, MD, Francis J	Philadelphia
SHEAFFER, MD, Harold C	Delaware
SHEARBURN III, MD, Edwin W	Bucks
SHEARER, MD, David M	York
SHEARER, MD, Donald E	Lycoming
SHEARER, MD, James E	Allegheny
SHECTER, DO, Fredric M	Philadelphia
SHEDD, MD, Ann C	Allegheny
SHEDLOCK, DO, Anthony F	Clearfield
SHEDRO, MD, Hector	Westmoreland
SHEEDY, MD, John G	Blair
SHEEHAN, MD, John H	Allegheny
SHEELY, MD, Raymond F	Adams
SHEEP, MD, Robert E	Chester
SHEER, MD, George W	Lackawanna
SHEETS, MD, Everett O	Philadelphia
SHEETS, MD, James A	Lehigh
SHEFFER, MD, M Leonard	Berks
SHELANSKI, MD, Sharon L	Philadelphia
SHELBY, MD, John H	Berks
SHELBY, MD, Joseph E	Fayette
SHELDON, MD, Douglas L	Lackawanna
SHELLEY, MD, Mark H	Allegheny
SHELLEY, MD, William L	Cumberland
SHELLING, MD, Richard E	Bradford
SHELLMAN, MD, Alexander	Lackawanna
SHELLY, MD, Elizabeth R B	Northampton
SHELLY, Mark A	Students
SHELLY, MD, Robert M	Susquehanna
SHELLY, MD, W Dayton	Wyoming
SHELLY, MD, Walter M	Northampton
SHELTON, MD, Barbara	Philadelphia
SHELTON, MD, Joseph M	Washington
SHEMANSKI, MD, Clem J	Berks
SHENBERGER, MD, Keith N	Lycoming
SHENFIELD, MD, Henry T	Bradford
SHENK, MD, Jonathan D	Dauphin
SHENKIN, MD, Henry A	Philadelphia
SHEPARD, MD, Kathleen A	Allegheny
SHEPPARD, MD, Frank J	Erie
SHEPPARD, Lisa M	Students
SHEPTAK, MD, Peter E	Allegheny
SHERAFAT, MD, Mostafa	Erie
SHERBAN, MD, Paul R	Lancaster
SHERIDAN, DO, Joseph F	Cambria
SHERMAN, MD, Alfred J	Dauphin
SHERMAN, MD, Cynthia A	Allegheny
SHERMAN, MD, Hanna B	Philadelphia
SHERMAN, MD, Henry K	Westmoreland
SHERMAN, MD, Hugh I	Mifflin/Juniata
SHERMAN, MD, M Jackson	Philadelphia
SHERMAN, MD, Randall L	Allegheny
SHERMAN, MD, Samuel	Allegheny
SHERRY, MD, Keith H	Dauphin
SHERRY, MD, Sol	Philadelphia
SHERTZER, MD, John H	Lancaster
SHERWIN, MD, Gerald P	Lehigh
SHERWIN, MD, Roberta	Philadelphia
SHERWIN, MD, William K	Delaware
SHERWOOD, MD, Arthur W	Wyoming
SHERWOOD, MD, John W	Luzerne
SHETE, MD, Leena P	Westmoreland
SHETH, MD, Pratima M	Philadelphia
SHETTY, MD, Ashok K	Westmoreland
SHETTY, MD, Karunakar S	Westmoreland
SHETTY, MD, Narayan	Beaver
SHETTY, MD, Ratnakar S	Beaver
SHETZLEY, MD, Carl M	Bucks
SHEVCHIK, MD, Grant J	Westmoreland
SHIBE, MD, William J	Philadelphia
SHIEH, MD, James C	Allegheny
SHIEH, MD, Kan C	Lehigh
SHIELDS, MD, Jerry A	Philadelphia
SHIELDS, MD, John J	Montgomery
SHIELDS, MD, Lee H	Dauphin
SHIELDS, MD, Mary S	Lehigh
SHIELDS, MD, Ralph L	Northampton
SHIELDS, MD, Thomas J	Montgomery
SHIELDS JR, MD, Richard A	Philadelphia
SHIN, MD, Grace E	Montgomery
SHIN, MD, Hyunchul J	Allegheny
SHIN, MD, Maung T	Erie
SHINDEL, MD, James H	Blair
SHINDLER, MD, Robert L	Dauphin
SHINGALA, MD, Arun J	Lackawanna
SHINN, MD, Elliott T	Beaver
SHINNICK, DO, James P	Philadelphia
SHIPKOVITZ, MD, Harvey D	Allegheny
SHIPLEY, MD, Alan E	Erie
SHIPPEN, MD, Eugene R	Berks
SHIREY, MD, Elaine D	Philadelphia
SHIREY, MD, Pamela S	Venango
SHISHAK, MD, Aryo A	Wayne/Pike
SHISLER, MD, Frederick H	Montgomery
SHIVDE, MD, Pinakini	Erie
SHLOMCHIK, MD, Seymour	Philadelphia
SHMOKLER, MD, Leon	Philadelphia
SHMOKLER, MD, Mitchell F	Delaware
SHOAFF, MD, Paris A	Lawrence
SHOCKMAN, MD, Joel	Philadelphia
SHOEMAKER, MD, David M	Bucks
SHOEMAKER, MD, Elliot I	Philadelphia
SHOEMAKER, MD, Margrit M	Allegheny
SHOEMAKER, MD, N Eugene	York
SHOEMAKER JR, MD, Lester E	Bucks
SHOENBERGER, Douglas C	Students
SHOENER, MD, John A	Allegheny
SHOENTHAL, MD, William J	Bucks
SHOLEHVAR, MD, Javad	Lehigh
SHONBERG, MD, Barbara H	Philadelphia
SHONBERG, MD, Irving L	Allegheny
SHOOK III, MD, Willis D	Allegheny
SHOPE, MD, Earl S	Cambria
SHOPE, MD, William B	Westmoreland
SHORE, DO, Eric E	Philadelphia
SHORE, MD, George R	Allegheny
SHORE, MD, Neal A	Philadelphia
SHORE, MD, Paul D	Delaware
SHORE, MD, Robert A	Montgomery
SHORE, MD, Roger J	Allegheny
SHORE, MD, Seymour M	Philadelphia
SHORE, MD, Sidney	Montgomery
SHORE, MD, Stephen R	Lehigh
SHORT, MD, Glenn M	Lehigh
SHORT, MD, William J	Cumberland
SHOUP, MD, George D	Philadelphia
SHOVLIN, MD, John M	Lackawanna

SHOWAN, MD, Ann Marie	Bucks
SHOWERS, Donna H	Students
SHRAGER, MD, Morton W	Philadelphia
SHROFF, MD, Farook K	Luzerne
SHU, MD, Chia S	Lycoming
SHUBERT, MD, Edward	Erie
SHUBIN, MD, Harry	Philadelphia
SHUE, MD, William M	York
SHUFFLEBARGER, MD, Charles M	Allegheny
SHUGAR, MD, Gary L	Berks
SHUGERT, MD, Guy S	Beaver
SHUGERT, MD, John H	Beaver
SHUKLA, MD, Rohitkumar S	Franklin
SHULKIN, MD, Mark W	Delaware
SHULKOSKY, Mark J	Students
SHULTZ, MD, Barry S	Berks
SHULTZ, MD, Margarita M	Lancaster
SHULTZ, MD, Robert G	Lancaster
SHULTZ, MD, Thomas L	Bucks
SHUMAN, MD, Charles R	Philadelphia
SHUMAN, MD, John F	Berks
SHUMAN, MD, Nancy A	Berks
SHUPAK, MD, Robt C	Philadelphia
SHUSMAN, MD, Robert S	Delaware
SHUSTER, MD, Eugene	Philadelphia
SHUSTER, MD, Harold F	Philadelphia
SHUSTERMAN, MD, Richard D	Philadelphia
SHUTTER, MD, Walter D	Westmoreland
SHUTTLEWORTH, MD, Lamont V	Allegheny
SHYAMALAN, MD, Jayalakshmi	Philadelphia
SHYAMALAN, MD, Nelliate C	Philadelphia
SHYNN, MD, Tae I	Lackawanna
SIA, MD, Jose K	Beaver
SIAR, MD, William J	Jefferson
SIBERSKI, MD, John R	Luzerne
SIBLEY, MD, Robert E	Lackawanna
SIBOLBORO, MD, Isabelo Z	Indiana
SICHER, MD, Bruno P	Mckean
SICKEL, MD, Edward F	Dauphin
SICONOLFI, MD, Ernest P	Allegheny
SIDHWA, MD, Dinshaw B	Berks
SIEBER, MD, William K	Allegheny
SIEGAL, MD, Edward I	Philadelphia
SIEGEL, Ayn D	Students
SIEGEL, MD, Bernard	Philadelphia
SIEGEL, MD, Joel	Allegheny
SIEGEL, MD, John E	Dauphin
SIEGEL, MD, Joseph F	Washington
SIEGEL, MD, Lawrence C	Philadelphia
SIEGEL, MD, Paul D	Philadelphia
SIEGEL, MD, Robert A	Columbia
SIEGEL, Scott S	Students
SIEGEL, MD, Selma F	Allegheny
SIEGEL, MD, Seymour	Philadelphia
SIEGEL, MD, William	Bucks
SIEGELBAUM, MD, Steven P	Dauphin
SIEGER, MD, Charles E	Lehigh
SIEGFRIED, MD, Jay W	Philadelphia
SIEGFRIED, MD, Myrtle M	Lehigh
SIEGLER, MD, Peter E	Philadelphia
SIEGRIST, MD, J Donald	Lancaster
SIEPER, DO, William J	Cambria
SIEPSER, MD, Steven B	Chester
SIESHOLTZ, MD, Thomas S	Bucks
SIEWERS, MD, Christiane	Allegheny
SIEWERS, MD, Ralph D	Allegheny
SIGAFOOS EXEC, SEC, Sally	Lancaster
SIGLER, MD, Miles H	Philadelphia
SIGMUND, MD, William J	Lancaster
SIGNORELLA, MD, Louis	Washington
SIH, MD, Philip G	Philadelphia
SIHA, MD, Victor L	Allegheny
SIKER, MD, Ephraim S	Allegheny
SILBERMAN, MD, Harvey D	Philadelphia
SILBERMAN, MD, Ira	Philadelphia
SILBERMAN, MD, J Dewolf	Lebanon
SILBERMAN, MD, Leslie J	Allegheny
SILBERMAN, MD, Robert M	Northampton
SILBERSTEIN, MD, Marsha M	Philadelphia
SILBERSTEIN, MD, Stephen D	Philadelphia
SILER, MD, Janet N	Philadelphia
SILIQUINI, MD, John J	Philadelphia
SILK, MD, Raymond E	Philadelphia
SILLA, MD, Enrique B	Philadelphia
SILLARS, MD, Charles H	Montgomery
SILON, MD, Nathaniel	Lehigh
SILVER, MD, Barry A	Montgomery
SILVER, MD, Bernice S	Philadelphia
SILVER, MD, Bruce G	Delaware
SILVER, MD, Dean R	Philadelphia
SILVER, MD, Frank	Philadelphia
SILVER, MD, Israel O	Dauphin
SILVER, MD, Laurence M	Montgomery
SILVER, MD, Lawrence B	Dauphin
SILVER, DO, Marc R	Philadelphia
SILVER, MD, Richard C	Delaware
SILVER, MD, Stephen C	Delaware
SILVERBERG, MD, Bruce J	Lehigh
SILVERBERG, MD, Daniel M	Lehigh
SILVERBERG, MD, Fred M	Allegheny
SILVERBERG, MD, Jay H	Allegheny
SILVERBERG, MD, Robert L	Berks
SILVERBLATT, MD, Bernard L	Allegheny
SILVERBLATT, MD, Marvin L	Allegheny
SILVERIO, MD, John	Chester
SILVERMAN, MD, Alan R	Allegheny
SILVERMAN, MD, Alexander	Allegheny
SILVERMAN, MD, Edward J	Berks
SILVERMAN, MD, Howard A	Lehigh
SILVERMAN, MD, Jerry D	Allegheny
SILVERMAN, MD, Joseph S	Blair
SILVERMAN, DO, Marvin J	Delaware
SILVERMAN, MD, Mendel	Allegheny
SILVERMAN, MD, Morton I	Lehigh
SILVERMAN, MD, Morton L	Lycoming
SILVERMAN, MD, Robert B	York
SILVERMAN, MD, William H	Northampton
SILVERMAN, MD, William S	Philadelphia
SILVERS, MD, Abigail A	Montgomery
SILVERS, MD, Arthur H	Delaware
SILVERSTEIN, MD, Alan J	Allegheny
SILVERSTEIN, MD, Alexander	Philadelphia
SILVERSTEIN, MD, Andrew M	Allegheny
SILVERSTEIN, MD, Gary S	Philadelphia
SILVERSTINE, MD, Leslie B	Mckean
SILVESTRI, MD, Archimede J	Philadelphia
SILVIS, MD, Harry J	Washington
SIM, MD, Hyun S	Armstrong
SIMAN, MD, Bernard	Philadelphia
SIMCOE, MD, James R	Montour
SIMENSON, MD, Robert A	Philadelphia
SIMKINS, MD, Jo M	Allegheny
SIMMONDS, MD, Mary A	Dauphin
SIMOES, MD, Antonio J	Montgomery
SIMON, MD, Nicolas V	York
SIMON, MD, William H	Philadelphia
SIMONE, MD, Frank J	Indiana
SIMONE, MD, Samuel T	Allegheny
SIMONIAN, MD, Simon J	Philadelphia
SIMONS, MD, Carl I	Bucks
SIMONS, MD, Howard M	Philadelphia
SIMONS, MD, Lawrence M	Philadelphia
SIMONS, MD, William M	Monroe
SIMONSEN, MD, Ronald W	Warren
SIMORA, MD, Felix S	Erie
SIMPSON, MD, Joseph W	Philadelphia
SIMPSON, MD, Richard A	Beaver
SIMPSON, MD, Roy W	Lackawanna
SIMPSON, MD, Zachary A	Bucks
SINAIKO, MD, Peter A	Bucks
SINCAVAGE, MD, Joseph T	Allegheny
SINCHIOCO, MD, Ceferino S	Allegheny
SINCLAIR, MD, Catherine P	Greene
SINCLAIR, MD, Michael C	Lehigh
SINCLAIR, MD, Ronald M	Philadelphia
SINCLAIR, MD, Sydney E	Lycoming
SINGER, MD, Barry L	Montgomery
SINGER, MD, Edward S	Philadelphia
SINGER, MD, Irvin	Philadelphia
SINGER, Jeffrey L	Allegheny
SINGER, MD, Jerome	Delaware
SINGER, MD, Joseph D	Philadelphia
SINGER, MD, Raymond L	Philadelphia
SINGER, MD, William H	Lehigh
SINGH, MD, Ajay P	Somerset
SINGH, MD, Amarjeet R	Beaver
SINGH, MD, Arvind K	Lackawanna
SINGH, MD, Bijai B	Indiana
SINGH, MD, Datar	Allegheny
SINGH, MD, Dilbagh	Mckean
SINGH, MD, Gurcharan	Philadelphia
SINGH, MD, Gurdial N	Northumberland
SINGH, MD, Navjeet	Philadelphia
SINGH, MD, Rajendra	Schuylkill
SINGH, MD, Sawraj	Montgomery
SINGH, MD, Surender	Lancaster
SINGH, Tejinder P	Allegheny
SINGLEY, MD, Thomas L	Beaver
SINGZON, MD, Jaime M	Northumberland
SINNENBERG JR, MD, Robert J	Lackawanna
SINOR, MD, Bakhti	Allegheny
SIPES, MD, Earl K	Lehigh
SIRIO, MD, Carl A	Dauphin
SIRIVELLA, MD, Srikrishna	Allegheny
SIRKEN, MD, Joseph G	Philadelphia
SIROTNAK, MD, John J	Lackawanna
SISSON III, MD, Robert F	Dauphin
SIU, MD, Clare C C	Wayne/Pike
SIVAK, MD, Stanley J	Warren
SIVENDRAN, MD, Tharmalingam	Adams
SIVICK, Donald A	Students
SIVITZ, MD, Jay M	Philadelphia
SIVITZ, MD, Marta E	Philadelphia
SIVITZ, MD, Michael C	Montgomery
SKARINSKY, MD, Eugenya	Philadelphia
SKARUPA, MD, Steven J	Allegheny
SKERL, MD, Anton O	Blair
SKERRETT, MD, Philip V	Philadelphia
SKETTINO, MD, Joseph A	Lackawanna
SKEZAS, MD, Marion	Allegheny
SKIENDZIELEWSKI, MD, John J	Montour
SKINNER, MD, Bruce S	Luzerne
SKINNER, MD, Douglas V	Allegheny
SKINNER III, MD, Robert W	Lancaster
SKLAROFF, MD, David M	Philadelphia
SKLAROFF, MD, Robert B	Philadelphia
SKOLE, MD, Simon M	Lawrence
SKOLNICK, MD, Kenneth B	Allegheny
SKOLNIK, MD, Neil S	Philadelphia
SKOVIRA, MD, Edward M	Lackawanna
SKOVRON, MD, Michael	Erie
SKOWRONSKI, MD, Theodore J	Montgomery
SKRENTA, MD, Richard J	Allegheny
SKRENTNY, MD, Thomas T	Blair
SKROMAK, MD, Stanley J	Philadelphia
SKUTCHES, MD, Joseph M	Northampton
SKVERSKY, MD, Norman J	Philadelphia
SKWEIR, MD, Leon A	Lehigh
SKWIRUT, MD, Frank A	Delaware
SLADEN, MD, Arnold	Allegheny
SLADKIN, MD, Kenneth R	Bucks
SLAGLE, MD, Edward H	Allegheny
SLAMOVITS, MD, Thomas L	Allegheny
SLAP, MD, Joseph W	Philadelphia
SLATER, MD, Craig M	Lawrence
SLATER, MD, Harvey	Allegheny
SLATER, MD, Kenneth C	Carbon
SLATER, MD, Robert	Delaware
SLATON, MD, Stephen S	Schuylkill
SLAVEN, Mark E	Allegheny
SLAVIN, MD, James W	Philadelphia
SLAVKIN, MD, Marvin D	Allegheny
SLEASE, MD, Cyrus B	Armstrong
SLEDZ, MD, Ann Marie	Northampton
SLEMENDA, MD, William D	Beaver
SLENKER, MD, Kevin F	Delaware
SLEZAK, MD, Joseph A	Westmoreland
SLIMMER JR, MD, Samuel C	Berks
SLIPPEY, MD, Alice E	Lancaster
SLIWINSKI, MD, Stanley J	Bucks
SLOAN, MD, Charles R	Fayette
SLOAN, MD, Gerald H	Cambria
SLOANE, MD, Charles E	Westmoreland
SLOANE, MD, Norman G	Philadelphia
SLOANE, MD, Paul	Philadelphia
SLOCUM, MD, Harold E	Montour
SLONE, MD, Jacob	Allegheny
SLOSS, MD, James O	Beaver
SLOTNICK, MD, Victor B	Philadelphia
SLOVAK, MD, James P	Lackawanna
SLOVAK, MD, John P	Lancaster
SLUHOCKI, DO, Mark	Luzerne
SLYSH, Nadia C	Students
SMAHA, MD, Lynn A	Bradford
SMALL, MD, Richard E	York
SMART, MD, Lawson C	Crawford
SMELTZER, MD, Kenneth L	Dauphin
SMIELL, MD, Janice M	Philadelphia
SMILEY, MD, Joseph W	Delaware
SMINK JR, MD, Robert D	Delaware
SMITH, MD, A Mitchell	Philadelphia
SMITH, MD, Alvin H	Philadelphia
SMITH, MD, Arthur E	Philadelphia
SMITH, MD, Arthur K	Philadelphia
SMITH, MD, Barton L	Berks
SMITH, Brian S	Students
SMITH, MD, Burgess A	Huntingdon
SMITH, MD, C Ross	Philadelphia
SMITH, MD, Cathy S	Delaware
SMITH, MD, Charles W	Dauphin
SMITH, MD, David A	Dauphin
SMITH, MD, David L	Philadelphia
SMITH, MD, Dean A	Philadelphia
SMITH, MD, Diana L	Philadelphia
SMITH, MD, Donald C	Luzerne
SMITH, MD, Donald H	Northampton
SMITH, MD, Earl B	Allegheny
SMITH, MD, Eddie L	Allegheny
SMITH, MD, Edgar C	Delaware
SMITH, MD, Edward G	Mercer
SMITH, MD, Ellen K	Montour
SMITH, MD, Eugene C	Lancaster
SMITH, MD, Forrest F	Franklin
SMITH, MD, Gary L	Allegheny
SMITH, MD, Gary M	Luzerne
SMITH, MD, Glen T	Philadelphia
SMITH, MD, Glenn O	Allegheny
SMITH, MD, Harold A	Lancaster
SMITH, MD, Henry F	Luzerne
SMITH, MD, Ian D	Lancaster
SMITH, MD, Ivan S	Montgomery
SMITH, MD, Jack D	Westmoreland
SMITH, DO, James A M	Erie
SMITH, MD, James M	Cumberland
SMITH, MD, James W	York
SMITH, DO, Jeffrey S	Greene
SMITH, MD, Jere P	Lehigh
SMITH, MD, John M	York
SMITH, MD, John W	Allegheny
SMITH, MD, Joseph L	Montour
SMITH, MD, Kaighn	Philadelphia
SMITH, Karen A	Students
SMITH, MD, Keith B	Mercer
SMITH, MD, Maria B	Delaware
SMITH, Mark H	Students
SMITH, MD, Mary L	Montgomery
SMITH, MD, Monica E	Philadelphia
SMITH, MD, Ora R	Philadelphia
SMITH, MD, Ralph W	Philadelphia
SMITH, MD, Raymond L	Berks
SMITH, MD, Raymond M	Lehigh
SMITH, MD, Richard H	Chester
SMITH, MD, Robert A	Delaware
SMITH, MD, Robert G	Warren
SMITH, MD, Robert W	Montgomery
SMITH, MD, Roger M	Montgomery
SMITH, MD, Ronald D	Philadelphia
SMITH, DO, Ronald K	Allegheny
SMITH, MD, Roy M	Allegheny
SMITH, MD, Russell C	Chester
SMITH, MD, Russell G	Allegheny
SMITH, Shawna D	Students
SMITH, MD, Stephen H	Bucks
SMITH, MD, Thomas W	Jefferson
SMITH, MD, Walter K	Westmoreland
SMITH, MD, Walter M	Bucks
SMITH, MD, Warren S	Allegheny
SMITH, MD, William D	Delaware
SMITH, MD, William P	Cambria
SMITH, MD, William T	Allegheny
SMITH JR, MD, Benjamin V	Allegheny
SMITH JR, MD, Chester L	Monroe
SMITH JR, MD, Edgar C	Philadelphia
SMITH JR, MD, George S	Lehigh
SMITH JR, MD, Harry A	Luzerne
SMITH JR, MD, J Stanley	Dauphin
SMITH JR, MD, Morgan T	Montgomery
SMITH JR, MD, Perry C	Washington
SMITH JR, MD, Ross H	Allegheny
SMITH JR, MD, Spencer R	Philadelphia
SMITH SR, MD, George S	Northampton
SMITH-FORSTER, MD, Jill D	Allegheny
SMITH-NGUYEN, MD, Gioi N	Philadelphia
SMOCK, MD, Richard A	Delaware
SMOGER, MD, Barry R	Montgomery
SMOLKO, MD, James R	York
SMOLKO, MD, Milan J	Lackawanna
SMOYER, MD, Ronald L	Cambria
SMUKLER, MD, Nathan M	Philadelphia
SMULLENS, MD, Stanton N	Philadelphia
SMYTH, MD, Lawrence T	Northampton
SMYTH, MD, Stephen H	Dauphin
SMYTH, MD, William T	Erie
SMYTHE, MD, Peggy A	Allegheny
SNEDDEN, MD, Hal E	Montgomery
SNEED, MD, Audrey G	Philadelphia
SNEFF, MD, Eugene M	Blair
SNIDER, MD, B Leonard	Erie
SNIPES, MD, Edward R	Philadelphia
SNODGRASS JR, MD, W Homer	Allegheny
SNOVER, MD, Seth W	Montour
SNOW, MD, Daniel S	Erie
SNOW, MD, Laurence H	Philadelphia
SNOW, MD, Ross A	Erie
SNOW JR, MD, James B	Philadelphia
SNYDER, MD, Alan I	Bucks
SNYDER, MD, Albert J	Delaware
SNYDER, MD, Allen P	Allegheny
SNYDER, MD, Barry J	Bucks
SNYDER, MD, Barry J	Clarion
SNYDER, DO, Courtney R	Philadelphia
SNYDER, MD, Diehl M	Lebanon
SNYDER, MD, Earl J	Lebanon
SNYDER, MD, Harry D	Montgomery
SNYDER, MD, Harvey B	Lebanon
SNYDER, MD, Henry R	York
SNYDER, MD, James V	Allegheny
SNYDER, DO, Jerrold M	Bucks
SNYDER, MD, John J	Dauphin
SNYDER, MD, John M	Northampton
SNYDER, MD, Kerman	Philadelphia
SNYDER, MD, Marvin C	Carbon
SNYDER, MD, Randall W	Lackawanna
SNYDER, MD, Richard C	Allegheny
SNYDER, MD, Richard L	Lancaster
SNYDER, MD, Richard W	Montgomery
SNYDER, MD, Robert J	Lehigh
SNYDER, MD, Robert L	Northampton
SNYDER, MD, Stanley	Lehigh
SNYDER, MD, Stuart	Philadelphia
SNYDER III, MD, Howard Mcc	Philadelphia
SNYDER JR, MD, Charles F	Northampton
SNYDER JR, MD, Charles P	Westmoreland
SNYDERMAN, MD, Ruben	Allegheny
SNYDMAN, MD, Leonard	Philadelphia
SOBELMAN, MD, Paul B	Lancaster
SOBER, MD, Diane M	Allegheny
SOBIESKI, MD, Joseph	Cambria
SOBOL, MD, Bernard H	Washington
SOBOLEWSKI III, DO, Victor J	Philadelphia
SOCRATES, MD, Jesus F	York
SODEMAN, MD, William A	Philadelphia
SOFFE, MD, Alvin M	Philadelphia
SOFFER, MD, Marvin	Philadelphia
SOFFIETTI, MD, John H	Butler
SOHN, Sae H	Students
SOISSON JR, MD, Ferdinand L	Cambria
SOKALCHUK, MD, Andrew	Philadelphia
SOKOL, MD, Joel H	Delaware
SOKOLOFF, Bruce H	Students
SOKOLOFF, MD, Mark I	Armstrong
SOLAN, MD, James A	Centre
SOLANO JR, MD, Francis X	Allegheny
SOLE, MD, Marylee	Philadelphia
SOLI, MD, Soleiman M	Philadelphia
SOLIC, MD, John J	Centre
SOLIS, MD, J Andrew	Philadelphia
SOLISH, MD, Lawrence	Philadelphia
SOLIT, MD, Robert W	Philadelphia
SOLL, MD, David B	Philadelphia
SOLLER, MD, Herbert I	Dauphin
SOLNICK, MD, Paul B	Philadelphia
SOLOFF, MD, Cynthia H	Allegheny
SOLOFF, MD, Paul H	Allegheny
SOLOMITO, Albert L	Students
SOLOMON, Clifford T	Students
SOLOMON, MD, Cynthia A	Luzerne
SOLOMON, MD, Elias M	Lancaster
SOLOMON, MD, Howard J	Allegheny
SOLOMON, MD, Macy B	Chester
SOLOMON, MD, Mark P	Philadelphia
SOLOMON, MD, Randall A	Allegheny
SOLOMON, MD, Robert C	Allegheny

SOLOMON, MD, Solomon D	Adams
SOLOMON, MD, Stephen J	Lebanon
SOLOSKO, MD, David	Allegheny
SOLOT, DO, Jerald A	Allegheny
SOLOW, MD, Irwin A	Allegheny
SOLTER, MD, Alan W	Allegheny
SOLWAY, MD, Sydney A	Westmoreland
SOMA, MD, Joseph J	Lackawanna
SOMANI, MD, Jagdish P	Allegheny
SOMANI, MD, Nirmala	Allegheny
SOMASUNDARAM, MD, Anasuya	Northampton
SOMERS, MD, Herbert J	Philadelphia
SOMERS, MD, Laurence A	Philadelphia
SOMERS, MD, Robert G	Philadelphia
SOMERS, MD, William R	Lycoming
SOMMA, MD, Richard M	Luzerne
SOMMARIPA, MD, Amory M	Philadelphia
SOMMER, MD, Deborah L	Allegheny
SOMMER, MD, John T	Delaware
SOMMERFELD, MD, James P	Lawrence
SOMMERVILLE, MD, Kenneth W	Lebanon
SON, MD, Daniel L	Philadelphia
SONBOLIAN, MD, Nasser	Allegheny
SONDER, MD, Max J	Philadelphia
SONDHEIMER, MD, Steven J	Philadelphia
SONG, MD, Michaela C	Philadelphia
SONG, MD, Sang W	Bucks
SONG, MD, Steven S	Montgomery
SONG, MD, Young J	Westmoreland
SONG, MD, Yung-Doo	Philadelphia
SONGSANAND, MD, Prachark	Allegheny
SONI, MD, Gurbax S	Mckean
SONNE, MD, John C	Philadelphia
SONNEBORN, MD, Duane G	Philadelphia
SONTHEIMER, MD, Gary G	Fayette
SOOD, MD, Sanjiv	Philadelphia
SOPCHAK, MD, Michael A	York
SOPHER, MD, Roger L	Philadelphia
SORARUF IV, MD, Louis P	Chester
SORBER, MD, William A	Lycoming
SORENSEN, MD, Alfred L	Washington
SORG, MD, Maurus L	Elk/Cameron
SORIANO, MD, Claver S	Allegheny
SORIANO, MD, Manuel G	Elk/Cameron
SORICELLI, MD, Richard R	Delaware
SORR, MD, Edward M	Allegheny
SOSIN, MD, Allan E	Philadelphia
SOSIS, MD, Arthur C	Lehigh
SOSS, DO, Murray C	Philadelphia
SOTELO, MD, Augusto	Westmoreland
SOTOODEHFAR, MD, Rahim	Allegheny
SOTOS, MD, L Nicholas	Armstrong
SOTOS, MD, Peter N	Armstrong
SOTOS, MD, Steven N	Allegheny
SOTUS, MD, Peter C	Mercer
SOUDER, MD, C Lawrence	Lehigh
SOUDER, MD, Francis R	Bucks
SOUDER, MD, Ronald L	Bucks
SOUDERS, MD, Thomas B	Berks
SOUILLIARD, MD, Donald H	Bucks
SOULEN, MD, Jeffrey L	Philadelphia
SOULEN, MD, Renate L	Philadelphia
SOUMERAI, MD, Simon	Philadelphia
SOUNDARARAJAN, MD, Ranganatha	Lycoming
SOUSER, MD, Roslyn C	Montgomery
SOVETSKY, DO, Charles L	Delaware
SOWERS, MD, John W	Franklin
SPADONI, MD, Joseph L	Northampton
SPADY, MD, Michael L	Philadelphia
SPAETH, MD, George L	Philadelphia
SPAGNA, MD, Paschal M	Philadelphia
SPAGNOLETTI, MD, Louis	Luzerne
SPAHR, MD, Robert C	Montour
SPANARD, MD, Russell A	Allegheny
SPANGLER, MD, John G	Montour
SPANGLER, DO, Martin L	Berks
SPANNUTH, MD, John R	Berks
SPANO, MD, Anselmo V	Delaware
SPANOGIANS, MD, Angelo J	Washington
SPARK, MD, Isadore	Philadelphia
SPEAR, MD, Barbara A	Bucks
SPEARS, MD, Laura S	York
SPECHT, MD, Charles S	Allegheny
SPECTER, MD, Jacob	Philadelphia
SPECTER, MD, Janet S	Philadelphia
SPECTOR, MD, Gus	Chester
SPECTOR, DO, Howard L	Luzerne
SPECTOR, MD, Martin	Philadelphia
SPEEDY, MD, Harry W	Westmoreland
SPEER, MD, Andrew B	Allegheny
SPEERS, MD, Herbert K	Bucks
SPEERS, MD, Rex W	Allegheny
SPEIDEL, MD, Francis X	Chester
SPELLER, MD, J Finton	Philadelphia
SPENCE, DO, Michael W	Monroe
SPENCER, MD, Donald Lynn	Chester
SPENCER, MD, H Newton	Delaware
SPERLING, MD, Herbert V	Allegheny
SPIEGEL, MD, Charles	Allegheny
SPIEGEL, MD, Daniel	Allegheny
SPIEGEL, MD, Joseph R	Philadelphia
SPIEGEL, Richard H	Students
SPIELMAN, MD, Charles C	Allegheny
SPIELMAN, MD, Scott R	Philadelphia
SPIGNER, MD, Donald W	Dauphin
SPILLMAN, MD, Murray K	Lancaster
SPILSBURY, MD, Paul R	Montour
SPINA, MD, Carmen M	Butler
SPINA, MD, Nancy R	Butler
SPINA JR, MD, Joseph	Delaware
SPINNER, MD, Morton H	Monroe
SPINNEY, MD, Carmen E	Lycoming
SPINO, MD, Pascal D	Westmoreland
SPIRO, DO, Arthur W	Philadelphia
SPIRO, MD, Richard I	Philadelphia
SPITLER III, MD, William M	Lancaster
SPITZ, MD, Eugene B	Philadelphia
SPITZ, MD, Lawrence K	Philadelphia
SPITZER, MD, Stanley	Philadelphia
SPIVACK, MD, Jack	Bucks
SPLAIN, DO, Dennis J	Lehigh
SPOCK, MD, Nicholas	Northumberland
SPOEHR, MD, Luther W	Allegheny
SPOLL, DO, Edward A	Northampton
SPOTTS, MD, Ricke L	Lebanon
SPRAGUE, MD, George S	Philadelphia
SPRANDIO, MD, John D	Philadelphia
SPRATT, MD, Charles E	Montgomery
SPRATT, MD, Robert H	Montgomery
SPRECHER JR, MD, Omer D	Franklin
SPRINGER, MD, Jay M	Montgomery
SPRINGER, MD, Roy A	Greene
SPRITZER, MD, Susan M	Allegheny
SPROUL, MD, Stephen M	Beaver
SPROWLS, MD, Jay R	Washington
SPYROPOULOS, MD, Nicholas G	Chester
SQUADRITO, MD, James F	Delaware
SQUADRITO JR, MD, James F	Montgomery
SQUIRES, MD, Kathleen E	Philadelphia
SRIDHARA, MD, C R	Philadelphia
SRIHARSHA, MD, Patalam S	Columbia
SRINIVASAGAM, MD, Narasimman	Allegheny
SRINIVASAN, MD, Venkatraman	Lycoming
SRITULANONDHA, MD, Nowaratana	Lancaster
SRIVASTAVA, MD, Sheonath P	Cambria
SRODES, MD, Charles H	Allegheny
SROUJI, MD, Maurice N	Philadelphia
SROUJI, MD, Samir J	Dauphin
SROUR, MD, James W	York
SRUR, MD, Jimmy S	Lebanon
STAAB, Jeffrey P	Allegheny
STAAS JR, MD, William E	Philadelphia
STABILE, MD, Jerome G	Northampton
STABLER, MD, Christine M	Lancaster
STACHER, MD, Eric D	Greene
STACK, MD, William T	Philadelphia
STACKHOUSE, MD, Duane E	Northampton
STACKOWSKI, MD, Maryjane	Union
STACKS JR, MD, Jacob C	Dauphin
STADER, MD, Richard O	Franklin
STADTMILLER, MD, Richard J	Cambria
STAFFEN, Robert N	Students
STAFFORD, MD, Calvin R	Delaware
STAFFORD, MD, Regis W	Allegheny
STAHL, MD, Robert W	Dauphin
STAHLE, MD, Dale C	Dauphin
STAHLMAN, MD, Frederick B	Clarion
STAHLMAN, MD, Roy A	Lancaster
STAHLNECKER, MD, C Stephen	Delaware
STAINBACK, MD, William C	Montgomery
STALEY, MD, Robert W	Allegheny
STALTER, MD, Ralph J	Allegheny
STALTERI, DO, Michael F	Delaware
STAMAN, MD, Harry	Allegheny
STAMATAKOS, MD, Michael J	Lehigh
STAMBOULY, MD, Joseph J	Allegheny
STAMM, MD, Barry D	Erie
STANCOMBE, MD, Wesley R	Northampton
STANDRE, MD, Mary L	Allegheny
STANEK, MD, Marjorie A	Philadelphia
STANEK, MD, Robert	Philadelphia
STANGER, MD, Robert H	Allegheny
STANILLA, MD, Joseph K	Montgomery
STANISH, MD, Frank X	Allegheny
STANISH, MD, Stanley M	Luzerne
STANITSKI, MD, Carl L	Allegheny
STANKOVIC, MD, Ljubisa	Dauphin
STANLEY, Christine L	Students
STANTON JR, MD, James N	Allegheny
STANTON JR, MD, John J	Philadelphia
STANULONIS, MD, Stanley W	Schuylkill
STAPLES, MD, Herman D	Delaware
STAPP, MD, Harriet L	Montgomery
STARER, MD, Larrimore J	Delaware
STARK, MD, Bruce I	Philadelphia
STARKEY, MD, Ralph H	Montour
STARKWEATHER, MD, George A	Delaware
STAROSCIK, MD, Rudolf N	Philadelphia
STARR, MD, Isaac	Philadelphia
STARRELS, MD, Michael E	Bucks
STARRELS, MD, Sidney H	Philadelphia
STARUNKO, MD, Basilio	Philadelphia
STARZ, MD, Terence W	Allegheny
STARZL, MD, Thomas E	Allegheny
STASCHAK, MD, Michael C	Allegheny
STASIK JR, MD, John J	Lehigh
STAUB, MD, Alice W	Philadelphia
STAUB JR, MD, Carl A	Delaware
STAUFFER, MD, Harold E	Lancaster
STAUFFER, MD, Stanley S	Northampton
STAVRIDES, MD, Alexander	Allegheny
STAWOVY, MD, Patricia A	Washington
STEC, MD, Eugene G	Lackawanna
STECHSCHULTE JR, MD, Donald W	Allegheny
STECKEL, MD, Donald C	Union
STEED, MD, David L	Allegheny
STEEGER, MD, Joseph R	Philadelphia
STEEL, MD, Howard H	Philadelphia
STEELE, MD, John E	Carbon
STEELE, MD, John F	Mercer
STEELE, MD, Logan H	Allegheny
STEELE, MD, R Edward	Dauphin
STEEN, MD, Oliver T	Allegheny
STEERMAN, MD, Paul H	Philadelphia
STEFANYSZYN, MD, Mary A	Philadelphia
STEFFENS, MD, Arnold O	Montgomery
STEFFY, DO, Harry L	Lancaster
STEGURA, MD, Barney A	Luzerne
STEIGERWALT, MD, John L	Montgomery
STEIGERWALT JR, MD, Robert D	Allegheny
STEIKER, MD, Daniel D	Philadelphia
STEIN, MD, Alan H	Cambria
STEIN, MD, Arthur V	Lehigh
STEIN, Betsy A	Students
STEIN, MD, David K	Philadelphia
STEIN, MD, Eleanor R	Dauphin
STEIN, MD, Franklin M	Philadelphia
STEIN, MD, George N	Philadelphia
STEIN, MD, Herbert	Philadelphia
STEIN, MD, Hymen D	Philadelphia
STEIN, MD, Irvin	Philadelphia
STEIN, MD, Natalio	Philadelphia
STEIN, MD, Raymond O	Philadelphia
STEIN, MD, Richard N	Northampton
STEIN, MD, Robert S	Northampton
STEIN, MD, Ronald A	Lehigh
STEIN, MD, Seymour	Philadelphia
STEIN, MD, Stanley I	Northampton
STEIN JR, MD, Donald B	Delaware
STEINBACH III, MD, William A	Lackawanna
STEINBERG, MD, Abraam	Allegheny
STEINBERG, MD, Arthur	Philadelphia
STEINBERG, MD, David R	Montgomery
STEINBERG, MD, Joel S	Philadelphia
STEINBERG, MD, Marvin E	Philadelphia
STEINBERG, MD, Nathan	Philadelphia
STEINBERG, MD, Robert A	Philadelphia
STEINBERG, MD, Stanley B	Philadelphia
STEINBERG, MD, William J	Philadelphia
STEINBOOK, MD, Melvin	Northampton
STEINBRINK, MD, William H	Erie
STEINDEL, MD, Carl R	Lackawanna
STEINER, Craig M	Allegheny
STEINFELD, MD, Michael L	Allegheny
STEINFELD, MD, Richard I	Mercer
STEINGARD, MD, Joseph J	Philadelphia
STEINMAN, MD, Arnold M	Allegheny
STEINMAN, MD, David	Allegheny
STEINMAN, MD, Robert C	Lancaster
STEINMETZ III, MD, Charles G	Philadelphia
STEINMEYER JR, MD, Harry H	Montgomery
STEKERT, MD, Ruth	Bucks
STELLA, MD, Joseph E	Lackawanna
STELLA, MD, Victoria G	Berks
STELLMACHER, MD, Virginia M	Lehigh
STELMACH, MD, Peter	Berks
STELMACH, MD, W Peter	Berks
STELZER, MD, Frederic A	Lehigh
STEM, MD, Lawrence R	Blair
STEM JR, MD, Theodore B	Allegheny
STEMMER, DO, Maryellen	Dauphin
STEMMLER, MD, Edward J	Philadelphia
STEMPEL, MD, Meredith D	Allegheny
STEN, MD, Jon D	Northumberland
STENCLIK, MD, Mark J	Erie
STEPANSKY, MD, David W	Montgomery
STEPANSKY, MD, William	Montgomery
STEPHAN, MD, Thorsten	Allegheny
STEPHENS, MD, Josephine M	Washington
STEPHENS, MD, Marilyn H	Centre
STEPHENS JR, MD, Harry W	Lehigh
STEPHENSON, MD, James B	Philadelphia
STEPHENSON, MD, Orlando K	Perry
STEPHENSON, MD, Patricia A S	Bucks
STEPHENSON, MD, Ruth	Philadelphia
STEPNICK, MD, David W	Allegheny
STEPPACHER, MD, Lester G	Philadelphia
STEPT, MD, Leonard A	Allegheny
STEPT, MD, Raymond	Allegheny
STEPT, MD, William J	Allegheny
STERLING, MD, Nancy I	Dauphin
STERN, MD, Lillian H	Philadelphia
STERN, MD, Robert M	Allegheny
STERNBERG, MD, Craig D	Philadelphia
STERNBURG, MD, Jon K	Wayne/Pike
STERNLIEB, MD, Sanford B	Luzerne
STETSON, MD, Derwood L	Franklin
STETZ, DO, Drew J	Montour
STEVENS, MD, Grant G	Columbia
STEVENS, MD, Michael A	Allegheny
STEVENS, MD, Robert G	Lycoming
STEVENS, MD, Stephen A	Allegheny
STEVENSON, MD, Peter T	Westmoreland
STEVENSON, MD, Richard D	Montgomery
STEWARD, Joanne A	Students
STEWARD JR, MD, Robert E	Centre
STEWART, MD, Alexander	Franklin
STEWART, MD, David A	Montgomery
STEWART, MD, Donald J	Allegheny
STEWART, MD, James A	Lycoming
STEWART, MD, Mervin S	Allegheny
STEWART, MD, Michael P	Lackawanna
STEWART, MD, Patricia E	Montgomery
STEWART, MD, Richard P	Dauphin
STEWART, MD, Russell R	Luzerne
STEWART, MD, Thomas A	Berks
STEWART, MD, William D	Allegheny
STEWART, MD, William P	Philadelphia
STEWART III, DO, Joseph H	Franklin
STEWART JR, MD, William G	Montgomery
STEYERS JR, MD, Curtis M	Berks
STICK, MD, Wesley D	York
STIEF, MD, Michael J	Northumberland
STIEGEL, MD, Robert M	Beaver
STIERSTORFER, MD, Max J	Lehigh
STIFFEL, MD, Arthur	Philadelphia
STIFFEL, MD, Jerry	Philadelphia
STILE, MD, Sabato A	Westmoreland
STILL, MD, George J	Mckean
STILLEY, MD, John W	Westmoreland
STINELY, MD, Regis W	Washington
STINEMAN, MD, Margaret G	Philadelphia
STISH JR, MD, Anthony G	Luzerne
STITT, MD, Donald G	Mercer
STITT, MD, Hugh I	Armstrong
STOCK, MD, Donald H	Philadelphia
STOFMAN, MD, Guy M	Philadelphia
STOFMAN, MD, Henry C	Philadelphia
STOKER, MD, John W	Blair
STOKES, Gordon K	Students
STOKES, MD, Ranjan	Philadelphia
STOLAR, MD, John	Warren
STOLLER, MD, Ronald G	Allegheny
STOLOFF, MD, Irwin L	Philadelphia
STOLTZFUS, MD, Elam R	Union
STOLTZFUS, MD, Virgil D	Lancaster
STOLZ, MD, John C	Berks
STOLZ, MD, Jonathan L	Berks
STOLZER, MD, Bertrand L	Allegheny
STONE, DO, Donald J	Columbia
STONE, MD, Hrant H	Philadelphia
STONE, MD, Jonathan D	Allegheny
STONE, MD, Ralph E	Fayette
STONE, MD, Robert K	Montgomery
STONE, MD, Walker H	Lycoming
STONE JR, MD, Charles S	Allegheny
STONER, MD, David C	Adams
STONER, MD, John C	Dauphin
STONER, MD, John G	York
STONER, MD, Max A	Dauphin
STONER, MD, Paul S	Dauphin
STONER, MD, Robert E	Lancaster
STONER JR, MD, Robert R	Dauphin
STOREY, MD, Patrick B	Philadelphia
STORM, MD, Charles T	Delaware
STORY, MD, Nancy S	Lycoming
STOTE, MD, Robert M	Philadelphia
STOTLER, MD, Charles W	Cambria
STOUDT, MD, Donald E	Berks
STOUDT, MD, K Donald	Mercer
STOUDT, DO, Kathy J	Berks
STOUFFER JR, MD, Vance R	York
STOUT, MD, William J	Lancaster
STOUTENBOROUGH, MD, Kenneth A	Lebanon
STOWE, MD, Jeffrey M	Philadelphia
STOWELL, MD, Joseph M	Blair
STRAKA, MD, John A	Allegheny
STRALEY, MD, Richard K	Lycoming
STRAMAT, MD, John M	Allegheny
STRASSMAN, MD, Ira H	Students
STRATFORD, Sandra D	Students
STRATTON, MD, Henry A	Philadelphia
STRATTON, MD, Robert D	Erie
STRAUS, MD, Joseph F	Philadelphia
STRAUSBAUGH, MD, Donald R	York
STRAUSBAUGH, MD, Janet T	York
STRAUSE JR, MD, Harold L	Berks
STRAUSS, MD, Melvin	Dauphin
STRAUSS, MD, Richard E	Bucks
STRAUSS, MD, Robert D	Lehigh
STRAUSSFOGEL, MD, Martin K	Northumberland
STRAVINO, MD, Vincent D	Northampton
STRAWITZ, MD, Joseph G	Philadelphia
STRAX, MD, Thomas E	Philadelphia
STRAYER, MD, David R	Philadelphia
STREET, MD, Thomas F	Luzerne
STREIFF JR, John J	Students
STRELEC, MD, Stephen R	Allegheny
STREMPLE, MD, John F	Allegheny
STRENGE, MD, Henry J	Philadelphia
STRETTON, MD, Jean B	Chester
STREUBERT, MD, George E	Northampton
STRIAR, MD, Jeffrey H	Montgomery
STRICKER, MD, Robert S	Luzerne
STRICKLER, MD, Jane A M	Centre
STRIMLAN, MD, C Vaughn	Allegheny
STRITE, MD, Joseph O	Franklin
STRITE JR, MD, James A	Adams
STRITTMATTER, MD, Isidor T	Philadelphia
STROCK, MD, Bradford K	Dauphin
STROCKBINE, MD, Melvin F	York
STRODE, MD, Marshall D	Chester
STRONG, Franklin D	Philadelphia
STRONG, MD, George H	Philadelphia
STROTHER, MD, George W	Cambria
STROUD, MD, Hilary A	Allegheny
STROUD III, MD, Morris W	Chester

STROUT, MD, Charles D Dauphin
STRUNK, MD, Thomas J Cambria
STRUNK, MD, William M Northampton
STRYKER, MD, John A Dauphin
STRZELECKI, MD, Zigmund F Bucks
STUARD, MD, I Donald Berks
STUART, MD, John C Allegheny
STUART, MD, Robert B Erie
STUBA, MD, Stella Montgomery
STUBBS, MD, G Winston Philadelphia
STUBBS, MD, John J Allegheny
STUCCIO, MD, Dominick A Luzerne
STUCCIO, MD, Joseph J Luzerne
STUCK, MD, Craig A Allegheny
STUCK, MD, Deborah L Allegheny
STUDDIFORD, MD, James S Philadelphia
STULL JR, MD, Walter F Lehigh
STUMPF, MD, Rebecca L Greene
STUPI, MD, Angela M Allegheny
STUPNIKER, MD, Sonia Philadelphia
STURGEON JR, MD, John D Fayette
STURGIS, MD, Katharine R Philadelphia
STURM, MD, Patrick W Beaver
STURM JR, MD, Charles F Allegheny
STUTMAN, MD, Fred A Philadelphia
STUTZ, MD, Martin Washington
STYPULA, MD, Richard W Mercer
SU, MD, Chao C Philadelphia
SU, MD, Chia-Chuen Franklin
SU, MD, Lang-Pao Lackawanna
SU, MD, Shyh-Min Allegheny
SUAREZ, MD, Ramon U Lebanon
SUATONI JR, MD, Frank J Allegheny
SUBBIAH, MD, Theuaraya N Butler
SUBRAMANY, MD, Narayanaswamy Elk/Cameron
SUFFREDINI, MD, Anthony F Allegheny
SUGAR, MD, Miklos Delaware
SUGARMAN, MD, Samuel Philadelphia
SUGDEN, MD, William A Bucks
SUGGS, MD, Nora A Lehigh
SUGIURA, MD, Henry T Philadelphia
SUGIURA, MD, Sumiko M Philadelphia
SUH, MD, Sang J Lackawanna
SUK, MD, Jin H Venango
SUKANICH, MD, Kriengsak Allegheny
SUKAROCHANA, MD, Kamthorn Allegheny
SULIK, MD, Ronald F Chester
SULLIVAN, MD, Daniel R Allegheny
SULLIVAN, MD, Edward M Delaware
SULLIVAN, MD, Howard E Montgomery
SULLIVAN, MD, John M Dauphin
SULLIVAN, MD, Lawrence X Allegheny
SULLIVAN, MD, Michael T Centre
SULLIVAN, MD, Robert D Cambria
SULLIVAN, MD, William A Dauphin
SULLIVAN, MD, William H Philadelphia
SULLUM, MD, Jonathan C Lackawanna
SULTZ, DO, Marvin E Philadelphia
SUMMERS, MD, David S Erie
SUMMERS, MD, Kermit L Lancaster
SUMMONS, MD, Howard J Berks
SUMNER, MD, Harold R Lawrence
SUN, MD, Elizabeth A Montgomery
SUN, MD, Evelyn L Philadelphia
SUN, MD, William Z Philadelphia
SUNDAY, Michael L Students
SUNDERLIN JR, MD, Frederick S Montour
SUNDERMAN, MD, F William Philadelphia
SUNDHEIM, MD, James L Lackawanna
SUNDMAKER, MD, Wilfried K Delaware
SUNDT, MD, Linda M Philadelphia
SUNG, MD, Chun M Allegheny
SUNG, MD, Duk I Allegheny
SUNG, MD, Lee H Westmoreland
SUNG, MD, Paul P Lawrence
SUNSERI, Maria J Allegheny
SUPER, MD, Leonid E Philadelphia
SUPERDOCK, Keith R Students
SUPPA, MD, Osvaldo S Erie
SUPRYS, Marianne J Students
SURI, MD, Ashok K Erie
SURKIN, MD, Marc I Delaware
SUSANN, MD, Philip W Erie
SUSEN, MD, Anthony F Allegheny
SUSI, MD, Jesse G Erie
SUSSMAN, MD, David Lehigh
SUSSMAN, MD, Marcel S Philadelphia
SUSSMAN, MD, Nathan Dauphin
SUSSMAN, MD, Sylvia Lehigh
SUTER, MD, Harry J Lycoming
SUTER, MD, Stanley C Lebanon
SUTLIFF, MD, Carlene S Dauphin
SUTLIFF, MD, Charles S Lycoming
SUTLIFF, MD, Frederick P Montgomery
SUTNICK, MD, Alton I Philadelphia
SUTTON, MD, Charles A Blair
SUTTON, MD, Paul L Montour
SUTTON, MD, Robert L Allegheny
SUTTON JR, MD, Edward L Butler
SUTTON JR, MD, John C Beaver
SUVARNAKAR, MD, Jawahar N Jefferson
SUWAN, MD, Manee Berks
SUWAN, MD, Nipapan Armstrong
SUWAN, MD, Sakdidej Armstrong
SWAGLER, DO, Curtis P Tioga
SWAIN, MD, Asha L Blair
SWAIN, MD, Pradip K Blair
SWALLOW, DO, William B Union
SWAMI, MD, Kumar Philadelphia
SWAMIDOSS, MD, Stephenson S Dauphin
SWAMY, MD, Mallekarjuna S Allegheny
SWAN, MD, Barbara E Allegheny
SWAN, MD, Reyer O Lancaster
SWAN, MD, Theodore H Montgomery
SWANK, MD, Mark D Dauphin
SWANSIGER, MD, Robert J Cambria
SWANSON, MD, Ernest W Mercer
SWANSON, MD, Michael D Allegheny
SWARTZ, MD, Edward F Franklin
SWARTZ, MD, Joel D Philadelphia
SWARTZ, MD, William M Allegheny
SWARTZ JR, MD, Oliver H Dauphin
SWEDA, MD, Stanley H Philadelphia
SWEENEY, MD, Bernard P Blair
SWEENEY, DO, Edward W Allegheny
SWEENEY, DO, Thomas F York
SWEENEY, MD, William F Allegheny
SWEENEY JR, MD, Francis J Philadelphia
SWEET, MD, William A Berks
SWEGAL, MD, Otto F Allegheny
SWEIGARD, MD, Keith W Montgomery
SWEIGART, MD, Gene M Bradford
SWEINBERG, MD, Sharon K Dauphin
SWENGROS, MD, Stephen G Philadelphia
SWENSEN, MD, Harold E Allegheny
SWENSEN, MD, Nancy M Allegheny
SWETERLITSCH, MD, Louis H Northampton
SWETERLITSCH, MD, Louis H Allegheny
SWICK 2ND, MD, J Howard Beaver
SWIDWA, MD, Denise M Allegheny
SWIERCZEWSKI, MD, Edward V Westmoreland
SWIFT, MD, Frank L Lackawanna
SYBING, MD, Eugenio A Mercer
SYBING, MD, Melita M Mercer
SYGENDA, MD, James T Philadelphia
SYKES, DO, Leroy I Dauphin
SYLVESTER, MD, Hans M Philadelphia
SYMONS, MD, John T Blair
SYMS, MD, Charles A Philadelphia
SYREK, MD, Susan J Montgomery
SZABO, MD, Emil R Huntingdon
SZABO, MD, Patricia E Delaware
SZABO, MD, Rudolph G Columbia
SZAKACS, MD, Juliana G Beaver
SZAL, MD, Joseph J Philadelphia
SZARKA, Christine E Students
SZARKO, MD, Frank J Berks
SZARKO, MD, Richard J Allegheny
SZAYNA, MD, Stanley Philadelphia
SZEBENYI, MD, Andrew G Montgomery
SZOKE, MD, Edward E Adams
SZUTOWICZ, DO, Michael P Lancaster
SZYDLOWSKI, MD, Thaddeus R Lebanon
SZYPULSKI, MD, Helen F Franklin

T

TABACHNICK, MD, Theodore M Allegheny
TABAS, MD, Gary Allegheny
TABLER, MD, Jan B Montgomery
TABOR, MD, Ellen K Allegheny
TABORA, MD, Emmanuel J Erie
TACHDJIAN, MD, Vahaken Philadelphia
TACHOVSKY, MD, Thomas J Northampton
TADDONIO, MD, Richard B Bucks
TAEFFNER, MD, John H Philadelphia
TAFFLIN, DO, Dennis H Bucks
TAFTAF, MD, Mohammad O Lawrence
TAGGART, MD, George W Luzerne
TAGGERT, MD, Charles Allegheny
TAGHIZADEH, MD, Firooz Fayette
TAGLE, MD, Elenita G Cambria
TAHIR, MD, Mahmod A Lehigh
TAIT, MD, Edwin C Montgomery
TAITELBAUM, MD, Ben Allegheny
TAKACH, MD, Stephen J Indiana
TAKEDA, MD, Misao Philadelphia
TALAGA, MD, Ronald N Wayne/Pike
TALBERT, MD, Madonna L Lancaster
TALBOT, MD, Gorge H Philadelphia
TALBOT, MD, Sheryl F Philadelphia
TALBOT JR, MD, Timothy R Philadelphia
TALBOTT, MD, John B Allegheny
TALENTI, David A Students
TALL, MD, Milton G Allegheny
TALLERICO, MD, Samuel J Allegheny
TALLMAN, MD, Edwin H Berks
TAMA, MD, Lawrence Bradford
TAMAKI, MD, H Tom Montgomery
TAN, MD, Antonius H Lehigh
TAN, Clinson B Students
TAN, MD, Edwin L Lackawanna
TAN, MD, Isabel G Mercer
TAN, MD, Josephine C Philadelphia
TAN, MD, Lian K Carbon
TAN, MD, Myrna M Philadelphia
TAN, MD, Tjiauw-Ling Dauphin
TAN, MD, Wilfredo S Erie
TAN, MD, Yoke Y Dauphin
TAN JR, MD, Ramon N Cambria
TANANIS, MD, Anthony A York
TANANIS, MD, Leonard J Schuylkill
TANCOR, MD, Benito Philadelphia
TANKER, DO, Mark S Philadelphia
TANNEHILL, MD, Norman B Allegheny
TANNENBAUM, MD, Philip J Philadelphia
TANNER, MD, Leonard M Lebanon
TANNING, MD, Howard M Allegheny
TANRIBILIR, MD, Abdul K Columbia
TANTISIRA, MD, Boonrak Allegheny
TANTISIRA, Kelan G Allegheny
TANTISIRA, MD, Somphong Westmoreland
TANTUM, MD, Kermit R Dauphin
TANYOL, MD, Hasib Montgomery
TANZER, MD, Peter P Allegheny
TAPYRIK, MD, Nicholas Beaver
TARROW, MD, Arthur B Philadelphia
TART JR, MD, Braston I York
TARWATER, MD, Doyle L Fayette
TASMAN, MD, William S Philadelphia
TATE, MD, Frederick J Lehigh
TATE, MD, J Harrison Erie
TATEM 3RD, MD, Henry R Bucks
TATTERSALL, MD, Harold A Monroe
TAUBER, MD, Joseph B Allegheny
TAUBER, MD, Robert Philadelphia
TAUBER, MD, Stanley A Philadelphia
TAUBERG, MD, Herbert R Allegheny
TAVANA, MD, Manoucher Erie
TAVARES, MD, Joao O Erie
TAVARIA, MD, Soli Schuylkill
TAVOULARIS, MD, Marjorie O Allegheny
TAX, MD, Richard L Bucks
TAYLOR, MD, Arthur R Lycoming
TAYLOR, MD, Craig L Adams
TAYLOR, MD, Gwendolyn D Bradford
TAYLOR, MD, Jacqueline Philadelphia
TAYLOR, MD, James A Monroe
TAYLOR, MD, James E Philadelphia
TAYLOR, MD, Marcia R Philadelphia
TAYLOR, MD, Morgan F Beaver
TAYLOR, MD, Philip C Philadelphia
TAYLOR, MD, Rodney J Allegheny
TAYLOR, MD, W J Russell Philadelphia
TAYLOR III, MD, James S Dauphin
TAYLOR JR, MD, Elmer J Philadelphia
TAYLOR JR, MD, John O Crawford
TCHIRKOW, MD, George Allegheny
TCHONG, MD, Kuo-Liang Delaware
TE, MD, Tomas T Bucks
TEDESCHI, MD, Albert A Berks
TEED, MD, Edward L Erie
TEEHAN, MD, Brendan P Montgomery
TEEPLE JR, MD, Edward Allegheny
TEET, MD, Daniel A Allegheny
TEETER, MD, James H Franklin
TEGZES JR, MD, George Allegheny
TEH, MD, Pek C Lawrence
TEICH, MD, Kenneth W Dauphin
TEICH, MD, Stephen M Montgomery
TEICHMAN, MD, Fred Union
TEITELBAUM, MD, Carl Luzerne
TEJPAR, MD, Mohamed K Lawrence
TEMELES, MD, Lawrence Philadelphia
TEMELES, MD, Roy S Allegheny
TEMPLE, MD, Anthony R Chester
TEMPLETON, MD, Bryce Philadelphia
TEMPLETON III, MD, John Y Philadelphia
TEMPLETON JR, MD, John M Philadelphia
TEMPLIN JR, MD, William B Cambria
TENENOUSER, MD, Barry Allegheny
TENICELA, MD, Ruben Allegheny
TENNY, MD, Claire M Philadelphia
TENSUAN JR, MD, Leonardo S Somerset
TEODORO, MD, Jose V Cambria
TEPLICK, MD, Joseph G Philadelphia
TEPLICK, MD, Steven K Philadelphia
TEPLITZKY, MD, Arthur L Philadelphia
TEPPER, MD, Maurice C Philadelphia
TEPPER, MD, Richard E Philadelphia
TEREDESAI, MD, Pradip R Allegheny
TERMINI, MD, Joseph T Lehigh
TERNER, MD, Irwin S Allegheny
TERWILLIGER, MD, Jerry W Bradford
TESSARO, MD, Anne N Allegheny
TESSLER, MD, A Robert Philadelphia
TESTA, MD, John W Luzerne
TESTA, MD, Joseph A Westmoreland
TESTER, MD, William J Philadelphia
TETALMAN, MD, Bruce I Allegheny
TETRICK, MD, Elbert L Allegheny
TEUFEL, MD, Severin Philadelphia
THAKARAR, MD, Pushpa Chester
THAL, DO, Stephen W Montgomery
THALER, MD, Malcolm S Philadelphia
THAMES, DO, Richard Jefferson
THANE, MD, Thane T Franklin
THANKI, MD, Ashokkumar S Delaware
THEERAKULSTIT, MD, Virachai Allegheny
THEIS, MD, Steven W Allegheny
THEL JR, MD, Henry C Beaver
THEMAN, MD, Terrill E Northampton
THEODOS, MD, Peter A Philadelphia
THETGYI, MD, Katherine Philadelphia
THEUERKAUF JR, MD, Frank J Erie
THEURKAUF JR, MD, Edward A Chester
THIELE, MD, Brian L Dauphin
THIERS, MD, George F Allegheny
THOFT, MD, Richard A Allegheny
THOMA, MD, George M Allegheny
THOMAS, MD, Bruce L Huntingdon
THOMAS, MD, Carmen C Philadelphia
THOMAS, MD, Chester G Dauphin
THOMAS, MD, Christopher W Crawford
THOMAS, MD, David E Allegheny
THOMAS, MD, Eugene L Philadelphia
THOMAS, MD, F Ardell Tioga
THOMAS, MD, George P Carbon
THOMAS, MD, Harold D Washington
THOMAS, MD, Harry L Philadelphia
THOMAS, MD, Henry W Allegheny
THOMAS, MD, James H Westmoreland
THOMAS, MD, John M Bradford
THOMAS, MD, John W Philadelphia
THOMAS, MD, John W Allegheny
THOMAS, MD, L Martha Ann York
THOMAS, MD, Nathan O Somerset
THOMAS, MD, Robert D Allegheny
THOMAS, MD, Thomas Venango
THOMAS, MD, Thomas K Jefferson
THOMAS, MD, Victor J Allegheny
THOMAS JR, MD, David W Clinton
THOMAS JR, MD, George P Carbon
THOMAS JR, MD, Harold D Beaver
THOMAS JR, MD, Howard P Bucks
THOMAS JR, MD, James A Delaware
THOMAS JR, MD, James J Erie
THOMPSON, MD, Bradford R Beaver
THOMPSON, MD, C Fred Northampton
THOMPSON, MD, Carson J Lackawanna
THOMPSON, MD, Charles M Philadelphia
THOMPSON, MD, Dan R Allegheny
THOMPSON, MD, David I Cumberland
THOMPSON, MD, Frank V Northampton
THOMPSON, MD, Harry J Armstrong
THOMPSON, MD, Herbert Allegheny
THOMPSON, MD, James S Allegheny
THOMPSON, MD, James W Montgomery
THOMPSON, MD, John E Warren
THOMPSON, MD, John W Allegheny
THOMPSON, MD, Linda L Beaver
THOMPSON, MD, Mark E Allegheny
THOMPSON, MD, Peter J Venango
THOMPSON, MD, Robert L Allegheny
THOMPSON, MD, Robert L Cumberland
THOMPSON, MD, T Ewing Allegheny
THOMPSON, MD, William G Allegheny
THOMPSON, MD, William W Elk/Cameron
THONET, MD, Marcel A Philadelphia
THORINGTON, MD, J Monroe Philadelphia
THORNE, MD, Charles G Chester
THORNSLEY, MD, Susan L Dauphin
THORNTON, MD, Eva A Lackawanna
THORNTON, MD, Joseph K Franklin
THORNTON III, MD, James J Delaware
THORP, MD, T Ramsey Philadelphia
THORSEN JR, MD, William B York
THORWARTH, MD, William T Philadelphia
THURMAN, MD, John N Delaware
TIAN, MD, Will T Mercer
TIBBELS, MD, Ewing W Bucks
TIBBENS, MD, George F Washington
TIBBITTS, MD, James A Lebanon
TIBERIO, MD, Richard A Fayette
TIBURCIO JR, MD, Albino F Butler
TICE, MD, Walter R Bucks
TICKNER, MD, Louis Philadelphia
TICZON, MD, Andres R Allegheny
TIETBOHL JR, MD, Ralph H Berks
TIETJEN, MD, George W Wayne/Pike
TIFFT, MD, Stephen W Lancaster
TIGER, MD, Melvyn E Philadelphia
TIGNOR, MD, Richard F Lycoming
TIHANSKY, MD, Dennis P Washington
TIHANSKY, MD, Theodore B Schuylkill
TILLGER, MD, John J Philadelphia
TILLMAN JR, MD, Joseph M Philadelphia
TILLY, MD, David A Lehigh
TILVA, MD, Praful K Northumberland
TIMEK, MD, Patricia A Cambria
TIMENS, MD, Lawrence J Cambria
TIMERDING, MD, Beverly L Allegheny
TIMNEY, MD, Thomas E Venango
TINDALL, MD, Dorothy D Montgomery
TINDALL, MD, Herbert L Lancaster
TINDALL, MD, Janice C Lancaster
TINNEY JR, MD, William S Lancaster
TINSLEY, MD, John P Monroe
TIO, MD, Tiong O Allegheny
TIONGSON, MD, Eleanor S Delaware
TIONGSON JR, MD, Jose G Delaware
TIPPING, MD, James S Allegheny
TIPTON, MD, Raymond L Venango
TIRACCHIA, MD, Joseph Philadelphia
TISHERMAN, MD, Samuel A Allegheny
TISHERMAN, MD, Samuel E Allegheny
TITCHWORTH, MD, Roy L Allegheny
TITUS, MD, Laborde Philadelphia
TOBIA, MD, Enio W Delaware
TOBIAS, MD, Gordon L Montgomery
TOBIAS, MD, Richard B Lycoming
TODARO, MD, Samuel R Lackawanna
TODHUNTER, MD, William D Lycoming
TODOROVSKA, MD, Zagorka Philadelphia
TOFF, DO, Kenneth J Lehigh
TOLAN, MD, Jeffrey R Dauphin
TOLAND, MD, Joseph C Philadelphia
TOLAND, MD, Joseph J Philadelphia
TOLAT, MD, Pratima R Philadelphia
TOLEDO, MD, Francisco L Philadelphia
TOLENTINO, MD, Julian C Butler
TOLENTINO, MD, Pablito L Bucks
TOLHURST, MD, Kirk D Bradford

TOLIN, Fredrik P — Allegheny
TOLIS, MD, Basile D — Blair
TOLLETT, MD, Charles A — Philadelphia
TOLLEVSEN, Linda M — Students
TOLMAN, MD, Leon M — Allegheny
TOLOFF, MD, Edward M — Allegheny
TOLPIN, MD, Eugene I — Bucks
TOLSCIK, MD, Richard Z — Montgomery
TOMARELLI, MD, Raymond C — Allegheny
TOMASELLO, MD, Donald N — Philadelphia
TOMASI, MD, Samuel J — Beaver
TOMASSETTI, MD, Bernard A — Philadelphia
TOMAZIC, DO, David R — Lackawanna
TOMCI, MD, George E — Westmoreland
TOME, MD, Robert E — Berks
TOMEDI, MD, John R — Luzerne
TOMEO, MD, Michael — Montgomery
TOMHAVE, MD, Robert H — Cambria
TOMKIEWICZ, MD, Thaddeus J — Berks
TOMLEY, MD, John E — Allegheny
TOMLIN, MD, Joseph — Schuylkill
TOMLINSON, MD, John W — Delaware
TOMLINSON, MD, John W — Bucks
TOMPA, MD, Alexander F — Lehigh
TOMPKINS, MD, H Ernest — Montgomery
TONDREAU, MD, Roderick L — Philadelphia
TONG, MD, Shiu Y — Philadelphia
TONKEN, MD, Harvey — Cambria
TONKONOW, MD, William — Philadelphia
TONREY, MD, Francis G — Luzerne
TOOF, MD, Richard S — Delaware
TOONDER, MD, F Geoffrey — Lehigh
TOOR, MD, Shaista N — Allegheny
TOOR, MD, Svinder S — Montour
TOOZE, MD, Frank M — Erie
TOPERZER, MD, Betty C — Erie
TOPORCER, MD, Mary B — Philadelphia
TORBAN, MD, Clara B — Philadelphia
TOREKI, MD, William — Bucks
TOREN, MD, Peter C — Montgomery
TORET, MD, Michel P — Westmoreland
TORI, MD, Joseph N — Chester
TORIN, MD, Jack E — Allegheny
TORIO, MD, Reynaldo M — Westmoreland
TORNAY, MD, Anthony S — Philadelphia
TORNETTA, MD, Frank J — Montgomery
TOROK, MD, Frank S — Washington
TORP, MD, Richard P — Cambria
TORPEY JR, MD, David J — Allegheny
TORRANCE, MD, Edward G — Delaware
TORRENCE, MD, Michael B — Delaware
TORRES, MD, Flora M — Bedford
TORRES, MD, Julio E — Northampton
TORRES, MD, Robin G — Bedford
TORRES, MD, Victor L — Philadelphia
TORRETTI, MD, Dennis — Montour
TORREY, MD, Edwin H — York
TOSO, MD, Gianfranco F — Berks
TOTINO, MD, Joseph A — Delaware
TOTO, MD, Andrew S — Philadelphia
TOUCH, MD, Ralph J — Lackawanna
TOURIGNY, MD, Paul R — Philadelphia
TOURTELLOTTE, MD, Charles D — Philadelphia
TOUSI, MD, Abbas H — Bedford
TOWNEND, MD, Stephen C — Chester
TOWNSEND, MD, Jay A — Cumberland
TOY, Stephanie M — Students
TRACHTE, MD, Thomas P — Berks
TRACHTENBERG, MD, Harry B — Chester
TRACHTENBERG, MD, Lee A — Allegheny
TRACHTENBERG, MD, William M — Lehigh
TRACY, MD, Gerald P — Lackawanna
TRAIMAN, MD, Richard G — Chester
TRAIN, MD, Henry D — Dauphin
TRAN, MD, George M T — York
TRAN, MD, Ngmia N — Philadelphia
TRAN, MD, Nhung T — Allegheny
TRANG, MD, Lien Bach — Allegheny
TRANOVICH, MD, Michael A — Allegheny
TRANSUE, MD, Seward M — Crawford
TRAUM, MD, Ronald E — Philadelphia
TRAUPMAN, MD, Arnold F — Northampton
TRAUTLEIN, MD, Joseph J — Dauphin
TRAVALINE, John M — Students
TRAVISANO, MD, Frank J — Dauphin
TREDENNICK, MD, Charles N — Butler
TREDENNICK, MD, John T — Cambria
TREGER, MD, Albert — Allegheny
TREIMAN, MD, Harris I — Bucks
TRELLIS, MD, Emil S — Allegheny
TREMBLAY, MD, Ernest A — Delaware
TRENT, Craig C — Allegheny
TRENT, MD, Douglas E — Westmoreland
TRESCOT, MD, Ronald E — York
TRESSLER, MD, Allene J M — Montgomery
TRETTA, DO, Joseph T — Cumberland
TREVASKIS, MD, Allan E — Lehigh
TREVI EXEC, DIR, John — Philadelphia
TREXLER, MD, Ethan L — Berks
TREXLER, MD, Harold L — Berks
TRIANO, MD, Gene J — Dauphin
TRIBBLE, MD, Jana K — Dauphin
TRIBIT JR, MD, Charles B — Philadelphia
TRIBOLETTI, MD, Frances M — Delaware
TRICHTINGER, MD, Martin D — Montgomery
TRIESTER, MD, Arthur N — Philadelphia
TRIMMER, MD, Michael N — Allegheny
TRIMMER JR, MD, John H — York

TRIMPI, MD, Howard D — Lehigh
TRINIDAD, MD, Tito B — Centre
TRINKLE, MD, Wilmer S — Northampton
TRIPI, MD, Joseph E — Adams
TRIPOLI, MD, Charles J — Washington
TRIPOLI, Louis C — Allegheny
TRISTAN, MD, Theodore A — Dauphin
TRIVEDI, MD, Gopalkrishna M — Mifflin/Juniata
TRIVUS, MD, Robert H — Allegheny
TROEN, MD, Philip — Allegheny
TROIANO, MD, Richard S — Beaver
TROIANOS, MD, Christopher A — Allegheny
TROILO, MD, Camillo T — Fayette
TROLLINGER, MD, Robert J — Philadelphia
TROMBETTA, Mark G — Students
TROMPETER, MD, Joseph I — Allegheny
TRONCELLITI, MD, A Wayne — Montgomery
TRONCELLITI, MD, Alfred E — Montgomery
TRONCELLITI, MD, Edward A — Montgomery
TRONCELLITI, MD, Manrico A — Montgomery
TRONCELLITI, MD, Mario V — Philadelphia
TRONZO, MD, Robert D — Allegheny
TROSTLE, MD, Douglas R — Lehigh
TROTT, Edward A — Students
TROUT, MD, John A — Westmoreland
TROUT, MD, Robert G — Philadelphia
TROXEL, MD, Richard S — Lehigh
TROYAN, MD, Beatrice P — Philadelphia
TRUDO, Edward W — Allegheny
TRUE, MD, A Curtis — Bucks
TRUITT, MD, George W — Chester
TRUITT, MD, Peter V — Berks
TRUITT JR, MD, R Marshall — Philadelphia
TRUITTE, David B — Allegheny
TRUJILLO, MD, Hernando — Bucks
TRUJILLO, MD, Rene — Wyoming
TRUMBORE, MD, David J — Allegheny
TRUMBULL, MD, Horace R — Berks
TRUMP, MD, David H — Dauphin
TRUSCOTT, MD, William R — Montgomery
TRUXAL, MD, Blair D — Allegheny
TRYGG, MD, Karen J — Philadelphia
TSAI, MD, Edward M — Indiana
TSAI, MD, Jer-Yuan — Greene
TSAI, MD, Ming C — Blair
TSAI, MD, Ming Che — Erie
TSAI, MD, Ming-Shang — Jefferson
TSAI, MD, Yu J — Montgomery
TSAI, MD, Yung-Hsien — Mercer
TSE, MD, Rose L — Philadelphia
TSOUTSOPLIDES, MD, George C — Columbia
TSUNG, MD, Wen-Han — Beaver
TUAN, MD, Bao-Kuen — Lackawanna
TUCHINDA, MD, Jalit — Allegheny
TUCKER, MD, Thomas W — Chester
TUDDENHAM, MD, William J — Philadelphia
TUFFAHA, MD, Hani J — Lycoming
TUFFIASH, MD, William A — Lehigh
TUFT, MD, Louis — Philadelphia
TUKANOWICZ, MD, Stanislaw A — Cambria
TUKE, MD, Gregory C — Berks
TULISZEWSKI, MD, Robert M — Adams
TULL, MD, John W — York
TULLAI, MD, John — Delaware
TULLY, MD, Vincent J — Wayne/Pike
TULSKY, MD, Emanuel G — Philadelphia
TUMAIAN, MD, Aram — Delaware
TUMEN, MD, Henry J — Philadelphia
TUNG, MD, Alfred S — Allegheny
TUNICK, MD, Stephen E — Allegheny
TUNKEL, MD, Allan R — Philadelphia
TUNNEY, MD, Doris F — Philadelphia
TURAKHIA, MD, Bharati V — Philadelphia
TURBESSI, MD, Albert J — Warren
TURCHI, MD, Pierre B — Franklin
TUREL, MD, Stanley E — Northampton
TUREL JR, MD, Anthony P — Montour
TURKEN, MD, Donald G — Berks
TURKEWITZ, MD, David — Montour
TURMAN, MD, Christopher — Philadelphia
TURNBLACER, MD, Charles B — Butler
TURNER, MD, Joseph — Allegheny
TURNER, MD, Keith S — Northampton
TURNER, MD, Margo E — Philadelphia
TURNER, MD, Martha — Philadelphia
TURNER, MD, Morris E — Allegheny
TURNER, MD, Oliver E — Allegheny
TURNER, DO, Richard L — Bucks
TURNER, MD, Thomas H — Erie
TURNER JR, MD, J Ellis — Delaware
TUROCK, MD, Michael J — Lackawanna
TURSI, MD, Joseph J — Philadelphia
TURSKY, MD, Rosemarie J — Dauphin
TURTZ, Alan R — Students
TURTZO, MD, Douglas F — Northampton
TURULA, MD, Jon B — Lancaster
TUSHIM, MD, Joseph N — Blair
TUTTLE, MD, Alfred — Allegheny
TUTTLE, MD, William B — Allegheny
TWAL, MD, Shafic Y — Indiana
TWARDY, MD, Bernadette E — Philadelphia
TWER, MD, Harris — Philadelphia
TWERSKI, MD, Abraham J — Allegheny
TWIGGAR II, MD, Edward V — Northumberland
TYMOCZKO, MD, Robert G — Westmoreland
TYMON, MD, Timothy P — Lancaster
TYNDALL, MD, Christine S — Allegheny
TYNDALL, MD, James A — Cumberland

TYSON, MD, James C — Dauphin
TYSON, MD, R Robert — Philadelphia
TYSON JR, MD, Russell R — Chester
TZANIS, MD, Loucas C — Dauphin
TZARNAS, MD, Chris D — Philadelphia

U

UBER, MD, Thomas R — Lawrence
UBINGER, Jeffrey P — Allegheny
UBINGER, MD, William N — Allegheny
UCMAKLI, MD, Alptekin — Philadelphia
UDARBE, MD, Guillermo G — Elk/Cameron
UDELL, MD, Louis — Philadelphia
UDOMSAK, MD, Paramin — Lackawanna
UDOSHI, MD, Geeta M — Luzerne
UDOSHI, MD, Mallapa B — Luzerne
UFBERG, MD, Michael H — Lehigh
UHL, Kathleen D — Students
UHLMAN, MD, Richard C — Chester
UHRICH, MD, Kathryn H — Lebanon
UHRICH, MD, Robert W — Lebanon
UHRICH, Susan E — Students
UKNIS, Audrey B — Students
ULICNY, MD, Thomas L — Allegheny
ULRICH, MD, Jack M — Allegheny
ULRICH, MD, Richard G — Dauphin
ULRICH, MD, Samuel D — Dauphin
ULRICH, MD, Wesley D — Delaware
ULUS, MD, Ahmet — Philadelphia
UMALI, MD, Idona C — Luzerne
UMAR, MD, Kenan — Montgomery
UMLAUF, MD, Charles W — Lehigh
UNDERHILL, MD, William L — Erie
UNDERWOOD, MD, Mara Z — Delaware
UNGAR-SARGON, MD, Julian Y — Delaware
UNGER, MD, Henry D — Philadelphia
UNIACKE, MD, Brian M — Allegheny
UNTEREKER, MD, William J — Philadelphia
UPANAVAGE, DO, Gene J — Carbon
UPDEGRAFF, Stephen A — Students
UPDEGRAFF, MD, William C — Allegheny
UPDEGROVE, MD, John H — Northampton
UPDEGROVE, MD, Robert A — Lycoming
UPDIKE JR, MD, Furman T — York
UPSON, MD, Dona J — Philadelphia
URAM, MD, Herbert — Allegheny
URANECK, MD, Katherine I — Philadelphia
URBACH, MD, Frederick — Montgomery
URBACH, MD, John R — Philadelphia
URBAN, MD, Clifford H — Montgomery
URBAN, MD, Donald G — Cumberland
URBAN, MD, Rena L — Allegheny
URBAN, MD, Richard S — Allegheny
URBAN, MD, Robert R — Westmoreland
URBANIAK, MD, Thomas F — Bucks
URBANO, MD, Tomas H — Allegheny
URBANSKI, MD, Timothy E — Montgomery
URIBE, MD, Alexander — Delaware
URICCHIO, MD, Joseph F — Philadelphia
UROSKIE, MD, Theodore W — Lackawanna
URREA, MD, J Oscar — Allegheny
USHINSKI, MD, Stanley C — Luzerne
UTBERG, MD, John R — Allegheny
UTSINGER, MD, Peter D — Montgomery
UY, MD, Henry T — Washington
UY, MD, Nonita T — Allegheny
UZYCH, MD, Walter — Delaware

V

VACCARELLO, MD, Luis — Allegheny
VACCARO, MD, Philip F — Washington
VACCARO, MD, V Michael — Philadelphia
VACCARO, MD, Vincent M — Delaware
VACHARAT, MD, Nibondh — Philadelphia
VACHRANUKUNKIET, MD, Theerasakdi — Philadelphia
VADILLO, MD, Alberto E — Delaware
VAGANOS, MD, Steve A — Philadelphia
VAGLEY, MD, Richard T — Allegheny
VAHEDI, MD, Houshang M — Montgomery
VAIDYA, MD, Shailendra — Philadelphia
VAKIL, MD, Hassan C — Delaware
VALCARCEL, MD, Sofronio J — Allegheny
VALDES, MD, Conrado A — Mckean
VALDIVIA, MD, Duilio E — Mifflin/Juniata
VALE, Robert M — Students
VALENA, MD, Elena V — Mercer
VALENA, MD, Loe V — Mercer
VALENCIA, MD, Celedonio C — Berks
VALENTEEN, MD, John W — Delaware
VALENTI, MD, John T — Luzerne
VALENTINE, MD, Jerome D — Philadelphia
VALENTINE, MD, Lee S — Allegheny
VALENZA, MD, Thomas C — Allegheny
VALERIANO, MD, James P — Allegheny
VALIGORSKY, MD, Paul J — Elk/Cameron
VALKO, MD, Annemarie P S — Allegheny
VALKO, George P — Students
VALLABH, MD, Sagar V — Mercer
VALLE, MD, Edgar O — Delaware
VALLEJO, MD, Manuel C — Washington
VALLESTEROS, MD, Federico P — Mercer
VALLIAPPAN, MD, Swaminathan — Allegheny
VALVERDE, MD, Mario F — Lackawanna
VAMADEVAMURTHY, MD, Molakalmuru H — Allegheny
VAN, MD, Kychuong — Allegheny
VAN DE BEEK, MD, M Louis — Philadelphia

VAN FLEET, MD, Timothy A — Allegheny
VANBUSKIRK, MD, Charles — York
VANDAMIA, MD, Donald N — Erie
VANDENBOSCH, MD, John T — Berks
VANDERBEEK, MD, Richard R — Bucks
VANDERLIN, MD, Robert L — Lycoming
VANDERPOOL, MD, Ramon A — Bucks
VANDERSCHILDEN, MD, John L — Montour
VANDERVEER, MD, Joseph B — Montgomery
VANDERVEER, MD, Lindsley D — Northampton
VANDUREN, Michael J — Allegheny
VANDUUREN, MD, Anton — Franklin
VANDYK, MD, Klaas — Westmoreland
VANEENWYK, MD, Fay J — Montgomery
VANETT, MD, Bruce B — Delaware
VANGIESEN, MD, Peter J — York
VANGUNDY, MD, Gregory A — Delaware
VANKIRK, MD, James K — Franklin
VANKIRK JR, James K — Allegheny
VANKIRK JR, MD, John S — Allegheny
VANLOON, MD, Emily L — Philadelphia
VANSANT, MD, Alan E — York
VANSCOTT, MD, Eugene J — Montgomery
VANSTRIEN, MD, Adrian R — Washington
VANVORIS, MD, Lee P — Erie
VANZANTEN, MD, Henry C — Mercer
VARANO, MD, Lottie A — Dauphin
VARANO, MD, Vincent J — Montour
VARCELOTTI, MD, Jorge R — Erie
VARDARO, MD, Lina G — Philadelphia
VARE JR, MD, Victor B — Montgomery
VARGA, MD, Arthur B — Fayette
VARGA, MD, Jeffrey M — Allegheny
VARKER, MD, Mary D — Philadelphia
VARLEY, MD, William J — Allegheny
VARMA, MD, Swarna — Allegheny
VARNER, MD, Lewis R — Clarion
VASA, MD, Mark A — Berks
VASILY, MD, David B — Northampton
VASQUEZ, MD, Ramon A — Allegheny
VASSALLUZZO, MD, Francis J — Bucks
VASSALLUZZO, MD, Julio E — Bucks
VASSALOTTI, MD, Stephen B — Philadelphia
VASTA, MD, Alfred G — Bucks
VASTINE, MD, John R — Northumberland
VASUDEVAN, MD, Gopalan — Westmoreland
VASUDEVAN, MD, Raghavan — Lycoming
VATAVUK, MD, Mark K — Erie
VATES, MD, Charles W — Allegheny
VAUGHAN, MD, Paul M — Beaver
VAUGHN JR, MD, Arthur R — Philadelphia
VEENIS, MD, Cornelius Y — Allegheny
VEERAPPAN, MD, Muthuveerappan — Blair
VEGA, MD, Rogelio E — Armstrong
VELAYO, MD, Dante P — Union
VELEZ, MD, Rafael I — Westmoreland
VEMULAPALLI, MD, Kutumbarao — Erie
VEMULAPALLI, MD, Lakshmi R — Erie
VENABLE JR, MD, John E — Erie
VENIER, MD, Leon H — Berks
VENIT, MD, Bethany A — Luzerne
VENTRE, MD, Susan — Lackawanna
VENTURA, MD, Cecilia R — Lackawanna
VENTURA, MD, Samuel R — Lackawanna
VENUGOPAL, MD, Prabha — Allegheny
VENZON, MD, Norman A — Westmoreland
VERBINSKI, MD, Ted — Berks
VERBRUGGEN, MD, Hugo C — Northampton
VERDECCHIA, MD, Leo M — Erie
VERDI, MD, Carol A — Philadelphia
VERGARE, MD, Michael J — Philadelphia
VERGNE, MD, Raymond — Allegheny
VERMEIRE, MD, David A — Mercer
VERNICK, MD, Clifford G — Lehigh
VERNICK, MD, Jerome J — Philadelphia
VERNINO, MD, Rocco A — Allegheny
VERNOCY, MD, William C — Indiana
VERNOCY, MD, William G — Indiana
VERONESI, DO, John N — Jefferson
VERSAGE, MD, Joseph L — Northampton
VESELY, MD, John A — Washington
VESOULIS, MD, Zissis — Bradford
VEY, MD, Edwin K — Allegheny
VICKERS, MD, Curtis W — Columbia
VICKERY, MD, Jon L — Dauphin
VICTOR, MD, Mark F — Philadelphia
VIDELL, DO, Jerry S — Philadelphia
VIECHNICKI, MD, Michael B — Lehigh
VIEK, MD, Nicholas F — Chester
VIGGIANO, MD, Louis X — Delaware
VIGILANTE, MD, Michael — Lehigh
VIGLIONE, MD, Joseph P — Monroe
VIKOREN, MD, Farah H — Bucks
VILBERT, MD, Benjamin F — Delaware
VILLA, MD, Francisco B — Potter
VILLACRUSIS, MD, Oscar C — Luzerne
VILLANOS, MD, Jesus M — Erie
VILLANUEVA, MD, Onofre Q — Venango
VILLARE, MD, Anthony W — Philadelphia
VILLASIN, MD, Joseph V — Lackawanna
VILLASIS, MD, Cynthia D — Delaware
VILLEGAS, MD, Antonio C — Montgomery
VILLEGAS, MD, Emilio — Westmoreland
VILLELLA, MD, Edward R — Allegheny
VILSACK, MD, G Ray — Allegheny
VIN, MD, Prakash K — Westmoreland
VINCENT, MD, Joseph E — Lehigh

VINER, MD, Edward D	Philadelphia
VINUEZA, MD, Tirso L	Chester
VIOLAGO, MD, Eduardo S	Dauphin
VIOZZI, MD, Francis J	Montour
VISNESKI, DO, Paul E	Lancaster
VISPERAS, MD, Emiliana P	Northampton
VISPERAS, MD, Mario F	Carbon
VISWANATHAN, MD, Byravan	Lebanon
VITALE, MD, Louis J	Lackawanna
VITKIN, MD, Elvina	Philadelphia
VITTO, Anthony	Students
VITTONE, MD, Ronald B	Westmoreland
VIVIAN, MD, Gail M	Chester
VIVINO, MD, F Bonelli	Philadelphia
VIZER, MD, Mark B	Bucks
VLACHOS, MD, Vasilios A	Chester
VLAHOS, DO, Patrick J	Allegheny
VLESSING, MD, Elias	Bucks
VOCI, MD, Gerardo	Philadelphia
VOGAN, MD, Clifford R	Armstrong
VOGAN, MD, William R	Mercer
VOGEL, MD, Adolph W	Delaware
VOGEL JR, MD, Julius A	Beaver
VOGIN, MD, Eugene E	Philadelphia
VOGLER JR, MD, Wilfred E	Northampton
VOGT, MD, Merle A	Delaware
VOLK, MD, Francis N	Philadelphia
VOLK, MD, Stephen A	Northampton
VOLKIN, MD, Leonard B	Allegheny
VOLKIN, MD, Robert L	Allegheny
VOLLMER, MD, Earl S	Montgomery
VOLOSON, MD, Kent J	Philadelphia
VOLPE, MD, Carmine	Philadelphia
VOLPETTI, MD, George W	Luzerne
VONCLEF III, MD, Julius S	Montgomery
VONRUEDEN, MD, David G	Delaware
VORA, MD, Prafullchandra	Greene
VORE, MD, Steven B	Centre
VOSSENBERG, MD, Frans J	Montgomery
VOUGHT, DO, Mickey B	Dauphin
VOUTSINAS, MD, Louisa V	Luzerne
VOYTKO, MD, Richard E	Cambria
VRABEC, MD, Donald P	Montour
VRABLIK, MD, Ronald M	Crawford
VRANIAN JR, MD, George	Philadelphia
VUJAN, MD, Alexander S	Allegheny
VUJAN JR, MD, Alexander S	Mercer
VUJEVICH, MD, Marion M	Allegheny
VUKMER, MD, George J	Venango
VUKMER, George J	Students
VUKMIR, Rade B	Allegheny

W

WACHS, MD, Hirsh	Allegheny
WADDINGTON, MD, Arthur W	Philadelphia
WADE, MD, Franklin G	Lycoming
WADE, MD, George R	Chester
WADEMAN, MD, Ross L	Berks
WADHWA, MD, Kamal P	Lawrence
WADHWA, MD, Rajindar K	Allegheny
WADHWA, MD, Saroj R	Allegheny
WADHWANI, MD, Bhagwan J	Washington
WAGENHEIM, MD, Harry H	Philadelphia
WAGENHEIM, MD, Helen S	Philadelphia
WAGMAN, MD, Albert D	Philadelphia
WAGMAN, MD, Philip G	Lawrence
WAGNER, MD, Charles W	Philadelphia
WAGNER, MD, David K	Philadelphia
WAGNER, MD, Jere L	Northumberland
WAGNER, MD, John B	Berks
WAGNER, MD, John M	Lackawanna
WAGNER, MD, Joseph A	Philadelphia
WAGNER, MD, Kenneth L	Bucks
WAGNER, MD, Louis J	Venango
WAGNER, DO, Mark E	Berks
WAGNER, MD, Robert A	Venango
WAGNER, MD, Robert E	Potter
WAGNER, MD, Seymour	Montgomery
WAGNER, MD, Tibor D	Montgomery
WAGNER, MD, W John	Lycoming
WAGNER JR, MD, Frederick B	Philadelphia
WAGNER JR, MD, John H	Allegheny
WAGNER JR, MD, Richard S	Lancaster
WAGNER JR, MD, Thomas E	Dauphin
WAHAL, MD, George A	Allegheny
WAHHAB, MD, Abdul	Schuylkill
WAHL, MD, Dayne F	Butler
WAIBEL, MD, David A	Lackawanna
WAIBEL, MD, John T	Blair
WAINER, MD, Amos S	Philadelphia
WAITE, MD, Knighton V	Allegheny
WALBERG, MD, Harry W	Allegheny
WALD, MD, Lawrence M	Philadelphia
WALD, MD, Michael E	Allegheny
WALD, MD, Niel	Allegheny
WALDEN, MD, Thomas B	Northampton
WALDHAUSEN, MD, John A	Dauphin
WALDMAN, DO, Barry S	Philadelphia
WALDMAN, MD, Clifford R	Blair
WALDMAN, MD, Joseph	Philadelphia
WALDMAN, MD, Sydney	Philadelphia
WALDMAN, MD, Terry L	Philadelphia
WALDO, MD, Ralph F	Indiana
WALDOR, MD, Philip A	Chester
WALICHUCK, MD, John G	Delaware
WALIGURA, DO, R Curtis	Allegheny
WALINSKY, MD, Paul	Philadelphia
WALKENSTEIN, MD, Michael D	Philadelphia
WALKER, MD, A Carl	Greene
WALKER, MD, Andrew B	Lehigh
WALKER, MD, Barry R	Philadelphia
WALKER, MD, Brian K	Centre
WALKER, MD, Herbert I	Philadelphia
WALKER, MD, James F	Erie
WALKER, MD, John E	Allegheny
WALKER, MD, Jon G	Lancaster
WALKER, MD, Leon R	Blair
WALKER, MD, M Lorenzo	Philadelphia
WALKER, MD, Margaret E	Philadelphia
WALKER, MD, Robert L	Montour
WALKER, MD, Stanley R	Northampton
WALKER, MD, Stephen R	Lehigh
WALKER JR, MD, Leroy L	Philadelphia
WALL, MD, John N	Allegheny
WALL, MD, Norman M	Schuylkill
WALL, MD, Rod A	Cambria
WALL, MD, Simon G	Allegheny
WALLACE, MD, Homer D	Allegheny
WALLACE, MD, Ira B	Philadelphia
WALLACE, MD, Richard P	Philadelphia
WALLACE, MD, Wilbur S	Erie
WALLACE JR, MD, Joseph	Delaware
WALLEN, MD, Albert D	Philadelphia
WALLENDJACK, MD, John C	Dauphin
WALLER, MD, Louis C	Allegheny
WALLER, MD, Louis C	Lackawanna
WALLERSTEIN, MD, Edward M	Erie
WALLEY III, MD, Robert E	Allegheny
WALLIN, MD, Thomas E	Dauphin
WALLNER, DO, Paul E	Philadelphia
WALMER, MD, John D	Lebanon
WALMSLEY, MD, James E	Chester
WALNISTA, MD, Frank J	Lackawanna
WALOFF, MD, Ronald I	Philadelphia
WALOR OFFICE, MGR, Mrs Margaret M	Westmoreland
WALRATH 3RD, MD, Martin H	Allegheny
WALSH, MD, Arthur C	Allegheny
WALSH, MD, James C	Luzerne
WALSH, MD, John J	Philadelphia
WALSH, MD, John J	Allegheny
WALSH, MD, Thomas F	Allegheny
WALSH, MD, Thomas R	Allegheny
WALSH, MD, Timothy A	Washington
WALTER, MD, David L	Venango
WALTER, MD, Earl R	Mifflin/Juniata
WALTER, MD, Willard F	Allegheny
WALTER, MD, William J	Allegheny
WALTERS, MD, William H	Schuylkill
WALTERS, MD, William S	Warren
WALTMAN, MD, Charles A	Northampton
WALTZ, MD, Paul K	Dauphin
WALTZER, MD, Frederick N	Montgomery
WAMPLER, MD, David L	Cumberland
WAMPLER, MD, Merle J	York
WANAMAKER, MD, John L	Bradford
WANCZYK, MD, Casimir J	Berks
WANDALOWSKI, MD, John G	Lackawanna
WANG, MD, Andreus	Bucks
WANG, MD, Barbara K	Westmoreland
WANG, MD, Chee Kung	Northampton
WANG, MD, George C	Delaware
WANG, MD, Shen-Chi	Mercer
WANG, MD, Yen	Allegheny
WANG, MD, Yung-Wen	Schuylkill
WAPNER, MD, John M	Lehigh
WAPNER, MD, Paul M	Philadelphia
WAPNER, MD, Ronald J	Philadelphia
WARD, MD, Edgar H	Erie
WARD, MD, Edward J	Delaware
WARD, MD, Frederick W	Northampton
WARD, MD, George W	Philadelphia
WARD, MD, H Richard	Union
WARD, Laurie A	Allegheny
WARD, MD, Mary J	Columbia
WARD, MD, Morton	Philadelphia
WARD, MD, Samuel P	Dauphin
WARD, MD, Stephen D	Montgomery
WARD, MD, Thomas A	Northampton
WARD JR, MD, Louis E	Fayette
WARDE, MD, Donal A	Allegheny
WARDEN, MD, James R	Erie
WARDEN, MD, Todd M	Philadelphia
WARDLOW, Robert D	Allegheny
WARE, MD, William B	Beaver
WARFEL, MD, Martin C	Erie
WARGO, MD, Peter J	Allegheny
WARIKOO, MD, Nanna	Cambria
WARIKOO, MD, Shiban K	Cambria
WARNER, MD, Francis J	Montgomery
WARNER, MD, Howard F	Philadelphia
WARNER, MD, Jeannette G	York
WARNER, MD, Norman M	Chester
WARNER, MD, Robert E	Allegheny
WARNER, MD, Robert H	Allegheny
WARNER, MD, Silas L	Philadelphia
WARNICK, MD, Richard D	Philadelphia
WARREN, MD, James Wm	Dauphin
WARREN, MD, Jonathan	Northampton
WARREN, MD, Kenneth C	Montgomery
WARREN, MD, William L	Chester
WARRENDER, MD, William F	Bucks
WARRENSKI, Joan	Students
WARTELLA JR, MD, Stephen	Luzerne
WASHBURN, MD, Virginia E	Allegheny
WASHBURNE, MD, Jaqueline D	Philadelphia
WASHICK, MD, Frank A	Philadelphia
WASHINGTON, MD, Buford S	Philadelphia
WASHKO-RECKNER, Rita M	Students
WASILEWSKI JR, MD, Charles L	Lycoming
WASKO, MD, Robert	Lehigh
WASLEY, MD, Douglas C	Delaware
WASNICK, MD, William	Luzerne
WASSER, MD, Samuel H	Philadelphia
WASSERMAN, MD, Ronald E	Lehigh
WASSERMAN, MD, Theodore W	Philadelphia
WASSIL, MD, John G	Mercer
WASSIL JR, MD, John G	Mercer
WASSNER, MD, Steven J	Dauphin
WATERS, DO, Patrick T	Philadelphia
WATKIN, MD, Walter B	Huntingdon
WATKIN JR, MD, Walter B	Dauphin
WATKINS, MD, Donald R	Mckean
WATSON, MD, Charles G	Allegheny
WATSON, MD, James G	Montgomery
WATSON, MD, James R	Allegheny
WATSON, MD, John C	Allegheny
WATSON, MD, Melvin E	Adams
WATSON, MD, T G	Mercer
WATSON, MD, Thomas M	Crawford
WATSON, MD, William B	Allegheny
WATSON, MD, William G	Allegheny
WATTENMAKER, MD, Bernard M	Allegheny
WATTERS, MD, Edmond C	Allegheny
WAWROSE, MD, Frederick E	Huntingdon
WAX, MD, Martin B	Montgomery
WAXMAN, MD, Herbert S	Philadelphia
WAY, MD, George E	Cambria
WAYLONIS, MD, Joseph R	Allegheny
WAYNE, MD, Dennis O	Allegheny
WEADER, MD, Joseph A	Montour
WEADER, MD, William M	Northumberland
WEAN, MD, Lawrence P	Delaware
WEANER JR, MD, Howard H	Lycoming
WEAVER, MD, Aaron R	Lancaster
WEAVER, Amy L	Students
WEAVER, MD, Don K	Lycoming
WEAVER, MD, Donald R	Bradford
WEAVER, MD, Frank M	York
WEAVER, MD, Harold P	Lehigh
WEAVER, MD, James D	Erie
WEAVER, MD, Kent E	Berks
WEAVER, MD, Lunda E	Blair
WEAVER, MD, M Fay	Berks
WEAVER, MD, R Clair	Lancaster
WEAVER, MD, Thomas D	Allegheny
WEBBER, MD, Carol P	Montgomery
WEBBER, MD, John B	Philadelphia
WEBER, MD, Daniel I	Dauphin
WEBER, Deborah E	Students
WEBER, MD, George L	Delaware
WEBER, MD, George W	Dauphin
WEBER, MD, John E	Allegheny
WEBER, MD, John I	Philadelphia
WEBER, MD, Lawrence	Allegheny
WEBER, MD, Martin R	Philadelphia
WEBER, MD, Otto R	Monroe
WEBER, MD, Richard H	Lancaster
WEBER, MD, William C	Northampton
WEBER, MD, William H	Union
WEBSTER, MD, Gordon W	Delaware
WEBSTER, MD, John H	Allegheny
WEBSTER, MD, Lane	Tioga
WEBSTER, MD, Wilma P	Columbia
WEBSTER JR, MD, Marshall W	Allegheny
WECHSLER, MD, Harry L	Allegheny
WECHSLER, MD, Richard J	Philadelphia
WECHSLER, MD, Richard L	Allegheny
WECHSLER, MD, Sylvia M	Allegheny
WECHT, MD, Cyril H	Allegheny
WEDDINGTON, MD, Wayne P	Philadelphia
WEDEEN, MD, Robert S	Chester
WEDEMEYER, MD, Anne L	Allegheny
WEDEMEYER, MD, Phillips P	Allegheny
WEE, MD, Choong Y	Northumberland
WEE, MD, Eng C	Mercer
WEED, MD, Allen S	Montgomery
WEHBE, MD, Marwan A	Philadelphia
WEIBEL, MD, David C	Union
WEIBEL, MD, Robert E	Delaware
WEIBEL, Timothy J	Students
WEIDA, MD, Thomas J	Lancaster
WEIDAW, MD, Harold R	Carbon
WEIDNER, MD, Calvin C	Northampton
WEIDNER, Sandra L	Students
WEIDNER, MD, William A	Dauphin
WEIGEL, MD, A Linn	Allegheny
WEIGEL, MD, Jesse A	Dauphin
WEIGEL, MD, Joseph H	Beaver
WEIGEL JR, MD, John E	Allegheny
WEIGHTMAN, MD, Joseph	Union
WEIGLER, MD, Richard R	Allegheny
WEIKERS, MD, Norbert J	Allegheny
WEILL JR, MD, David R	Allegheny
WEIMER, MD, Bruce J	Allegheny
WEIMER, MD, Gregory R	Centre
WEIN, MD, Alan J	Philadelphia
WEIN, MD, Thomas P	Allegheny
WEINBAUM, MD, David L	Allegheny
WEINBERG, MD, Carroll A	Delaware
WEINBERG, MD, Ethel	Philadelphia
WEINBERG, MD, J David	Lancaster
WEINBERG, MD, Joel H	Allegheny
WEINBERG, MD, Richard A	Delaware
WEINBERG, MD, Richard L	Allegheny
WEINBERG, MD, Saul A	Philadelphia
WEINBERGER, MD, Emanuel M	Philadelphia
WEINBERGER, MD, Irving G	Allegheny
WEINBERGER, DO, Richard L	Lackawanna
WEINBLATT, MD, Howard A	Philadelphia
WEINER, MD, Frank	Indiana
WEINER, MD, Gerald H	Lawrence
WEINER, MD, Harold M	Montgomery
WEINER, MD, Herman L	Philadelphia
WEINER, MD, Jack	Philadelphia
WEINER, MD, Jeffery R	Montgomery
WEINER, MD, Leon J	Philadelphia
WEINER, MD, Roger D	Delaware
WEINER, MD, Sidney	Allegheny
WEINFELD, MD, Mieczyslaw	Allegheny
WEINGARTEN, MD, Michael S	Philadelphia
WEINGROD, MD, Carol E	Lehigh
WEINSTEIN, DO, Allen J	Lehigh
WEINSTEIN, MD, David P	Westmoreland
WEINSTEIN, MD, Gary S	Allegheny
WEINSTEIN, MD, George L	Philadelphia
WEINSTEIN, MD, Jack L	Philadelphia
WEINSTEIN, MD, Lee	Dauphin
WEINSTEIN, MD, Robert S	Philadelphia
WEINSTEIN, MD, Saul F	Philadelphia
WEINSTOCK, MD, Andrew I	Lancaster
WEINSTOCK, MD, Jerome L	Montgomery
WEINSTOCK, MD, Martin A	Allegheny
WEINSTOCK, MD, Robert M	Philadelphia
WEINTRAUB, MD, Harvey	Berks
WEINTRAUB, Ilene D	Allegheny
WEINTRAUB, MD, William H	Philadelphia
WEIR, MD, Thomas F	Allegheny
WEIS, DO, John H	Bradford
WEIS, MD, Paul R	Lehigh
WEISBAND, MD, Benjamin J	Allegheny
WEISBAUM, MD, Simcheon D	Luzerne
WEISBERG, MD, Edward S	Allegheny
WEISBERG, MD, Jerome S	Berks
WEISBERG, MD, Paul B	Philadelphia
WEISBERG, MD, Robert A	Bucks
WEISEL, MD, Robert H	Carbon
WEISEL, MD, William M	Westmoreland
WEISEL JR, MD, William F	Bucks
WEISENFLUH, Mark G	Students
WEISER, MD, Madeleine C	Montgomery
WEISMAN, MD, Dale M	Northampton
WEISMAN, MD, Richard A	Allegheny
WEISMER, MD, Richard M	Lancaster
WEISS, MD, Alan R	Montgomery
WEISS, MD, Albert A	Philadelphia
WEISS, MD, Burton	Philadelphia
WEISS, MD, Carl B	Monroe
WEISS, MD, Charles	Philadelphia
WEISS, MD, David L	Philadelphia
WEISS, MD, Edward D	Philadelphia
WEISS, MD, Elissa	Allegheny
WEISS, MD, George H	Montgomery
WEISS, MD, Jeffrey P	Lackawanna
WEISS, MD, Jordan B	Philadelphia
WEISS, MD, Larry D	Allegheny
WEISS, MD, Malcolm S	Allegheny
WEISS, MD, Michael W	Allegheny
WEISS, MD, Robert	Philadelphia
WEISS, MD, Robert F	Allegheny
WEISS, MD, Robert J	Warren
WEISS, MD, Sidney	Philadelphia
WEISS, MD, Stephen M	Philadelphia
WEISS, MD, William	Luzerne
WEISS, MD, William	Philadelphia
WEISSER, MD, C William	Allegheny
WEISSMAN, MD, Jerry	Butler
WEISSMAN, MD, Joel M	Philadelphia
WEISSMAN, MD, Marcus I	Philadelphia
WEITEKAMP, MD, Michael R	Dauphin
WEITZEL, MD, William K	Allegheny
WELCH, MD, John B	Montour
WELDON, MD, John F	Washington
WELLENBACH, MD, Burton L	Philadelphia
WELLER, MD, Carl A	Northumberland
WELLER, MD, Russell W	Chester
WELLMAN, MD, Richard H	Butler
WELLS, MD, E Buist	Erie
WELNER, MD, Alan H	Philadelphia
WELSCH, MD, Frank A	Bucks
WELSH, MD, James F	Berks
WELSH, MD, John J	Montgomery
WELSH, MD, Louis W	Montgomery
WELTY, MD, John W	Philadelphia
WEMPLE, MD, Jan B	Northampton
WENDELL JR, MD, James I	Montgomery
WENDER, MD, Richard C	Philadelphia
WENDLING, MD, Woodrow W	Philadelphia
WENG, MD, Sam S	Northampton
WENGER, MD, Jay A	Bucks
WENGER, MD, Marlin E	Lancaster
WENGER, MD, Norman E	Lackawanna
WENGER, MD, Robt K	Philadelphia
WENGER, MD, Sidney U	Philadelphia
WENGERT, MD, Paul A	Dauphin
WENGROVITZ, MD, Paul H	Centre
WENIGER, MD, Frederick C	Allegheny
WENIGER, MD, Frederick L	Allegheny
WENNER, MD, Robert B	Luzerne
WENNERSTEN, MD, Jack R	Montgomery
WENTZ, MD, Henry S	Lancaster
WENTZ JR, MD, Walter E	Delaware
WENTZEL, MD, H Earl	Philadelphia
WENTZLER, MD, J Donald	Union
WERLEY, MD, Charles W	Northampton
WERLEY, MD, John D	Northampton
WERLEY, MD, Walter W	Berks
WERNER, MD, A William	Erie

WERNER, MD, David B	Centre
WERNER, MD, Donald J	Lackawanna
WERNER, MD, Elliot B	Philadelphia
WERNER, MD, Gerhard	Allegheny
WERNER JR, MD, Joseph H	Bucks
WERT, MD, Roy E	Bradford
WERTHAN, MD, Merylee E	Philadelphia
WERTHEIM, David L	Students
WERTHEIMER, MD, John H	Philadelphia
WERTHEIMER, MD, Marc J	Delaware
WERTHER, MD, Norman M	Montgomery
WERTIME, MD, Clara G	Dauphin
WERTZ, MD, Robert E	Blair
WERTZ, MD, Robert R	Cambria
WESCHLER, MD, Barbara	Allegheny
WESDOCK, James C	Students
WESLER, MD, Lee S	Philadelphia
WESSEL, MD, Isadore J	Philadelphia
WEST, MD, Edward	Centre
WEST, MD, John C	Montour
WEST, MD, Robert B	Mifflin/Juniata
WEST, MD, William B	Huntingdon
WEST, MD, William J	Cumberland
WEST JR, MD, Clifton F	Montgomery
WEST JR, William J	Students
WESTCOTT, MD, Richard J	Berks
WESTENDORP, MD, Andre C	Berks
WESTGATE, MD, Randy R	Lancaster
WESTON, MD, David M	Lancaster
WESTON, MD, Jon-Marc	Philadelphia
WESTON, MD, Kenneth R	Lehigh
WESTRICK, MD, Diann M	Allegheny
WETMORE, MD, Ralph F	Philadelphia
WETMORE, MD, Stanley M	Dauphin
WETSCHLER, MD, Stanley S	Allegheny
WETSTONE, MD, Jeffrey B	Lycoming
WETTLAUFER, MD, Marilyn R	Philadelphia
WEXLER, MD, Amy R	Philadelphia
WEXLER, MD, Harry	Philadelphia
WEXLIN, MD, Donald J	Montgomery
WEYLAND, MD, Charletta K	Lebanon
WEYN, David C	Students
WHALEN, MD, Edward C	Montgomery
WHALEN, MD, John J	Montgomery
WHALEN, MD, Thomas J	Washington
WHARTON, MD, Stanley W	Erie
WHEATLY, MD, William K	Lancaster
WHEELER, MD, Glen N	Lebanon
WHEELER, MD, Leigh D	Centre
WHEELING, MD, George H	Cambria
WHELAN, MD, Stephen T	Delaware
WHELAN, MD, Thomas P	Philadelphia
WHETZEL, MD, Thomas P	Allegheny
WHILDIN, MD, James G	Northampton
WHIPPLE, MD, Dorothy S	Philadelphia
WHITAKER, MD, H Craig	Delaware
WHITAKER, MD, J Michael	Bucks
WHITAKER, MD, Linton A	Philadelphia
WHITAKER, MD, Paul J	Northampton
WHITCOMB, MD, Clarence A	Philadelphia
WHITCOMB, MD, Luther M	Cumberland
WHITE, MD, Albert E	Bucks
WHITE, Aruby O	Students
WHITE, MD, Daryl E	Franklin
WHITE, MD, David A	Washington
WHITE, MD, David M	Philadelphia
WHITE, MD, George S	Centre
WHITE, MD, Jack C	Chester
WHITE, MD, Joseph G	Chester
WHITE, MD, Peter	Philadelphia
WHITE, MD, Richard F	Bucks
WHITE, MD, Richard K	Lehigh
WHITE, MD, Robert A	Delaware
WHITE, MD, Robert E	Mckean
WHITE, MD, Robert P	Northampton
WHITE, MD, Warren F	Cambria
WHITE, MD, Wayne D	Dauphin
WHITE, MD, Wesley R	Lackawanna
WHITE, MD, William L	Allegheny
WHITE EXEC, SEC, Ms Anne L	Fayette
WHITE JR, MD, Robert H	Lancaster
WHITELEY, MD, John P	York
WHITEMAN, MD, Mitchell S	Philadelphia
WHITENACK, MD, Stephen H	Philadelphia
WHITESELL, MD, Gary J	Butler
WHITESIDE, MD, Virginia E	Allegheny
WHITMAN, MD, Lewis V	Allegheny
WHITMAN, MD, Mark A	Bucks
WHITMAN, MD, Randal L	Philadelphia
WHITMAN, MD, Robert S	Allegheny
WHITMAN, MD, Victor	Dauphin
WHITMORE, MD, John T	Bedford
WHITMORE, MD, Mason	Delaware
WHITSON, MD, David W	Lehigh
WHITTAKER, MD, Richard P	Montgomery
WHITTEN, MD, Christopher J	Philadelphia
WHITTEN, MD, Warren L	Indiana
WHOLEY, MD, Mark H	Allegheny
WIBLE, MD, Claire E	York
WIBLE, MD, Leroy C	Allegheny
WIBULOUTAI, MD, Boonterm	Beaver
WICK, MD, John L	Butler
WICKERHAM JR, MD, Earl P	Allegheny
WICKEY, MD, Gregory S	Dauphin
WICKRAMASINGHE, MD, Eardly K	Erie
WICKS, MD, William A	Luzerne
WIDDOWSON, MD, Harold R	Delaware
WIDELITZ, MD, Martin M	Philadelphia
WIDER, MD, Saul	Philadelphia
WIDGE, MD, Toeruna S	Lehigh
WIDLAN, MD, Sheldon	Westmoreland
WIDLITZ, MD, Michael D	Bucks
WIDOME, MD, Mark D	Dauphin
WIECK, MD, Edwin E	Philadelphia
WIECZOREK, MD, J Eric	Armstrong
WIEDER JR, MD, Henry S	Philadelphia
WIEGERING, MD, Carlos A	Blair
WIEMANN, MD, George F	Philadelphia
WIENER, MD, David H	Montgomery
WIENER, MD, Eugene S	Allegheny
WIENER, MD, Jacob	Philadelphia
WIENER, MD, Stephen G	Berks
WIESENFELD, MD, Nathaniel H	Luzerne
WIESNER, MD, Irving S	Delaware
WIEST, MD, Hiram L	Dauphin
WIEST, MD, Philip R	Berks
WIGERT, MD, Walter S	Tioga
WIGHT, MD, Susan C	Philadelphia
WIGLE, MD, Arnold R	Westmoreland
WIKLER, MD, Joan G	Bucks
WIKLER, MD, Louis A	Philadelphia
WIKLER, MD, Matthew A	Montgomery
WILBERGER JR, MD, James E	Allegheny
WILCOX, MD, Wilfred W	Lycoming
WILCOX JR, MD, Winthrop P	Lancaster
WILD JR, MD, Robert M	Centre
WILDBLOOD, MD, Harry M	York
WILDER, MD, Bruce L	Allegheny
WILDER, MD, David W	Cambria
WILDERMAN, MD, Barry S	Bucks
WILDRICK, MD, Kenneth H	Northampton
WILEY, MD, Bert C	Blair
WILEY, DO, David E	Lancaster
WILEY, MD, Susan D	Lehigh
WILF, MD, Harold	Philadelphia
WILFONG, MD, Donald J	Allegheny
WILHELM, MD, William C	Erie
WILKERSON, MD, Joseph L	Delaware
WILKINS, MD, Byron D	Lehigh
WILKINS, MD, Daniel M	Allegheny
WILKINSON, MD, David M	Montour
WILKINSON, MD, Harold A	Delaware
WILKINSON, MD, John H	Allegheny
WILKINSON, MD, Roselise H	Delaware
WILKINSON, MD, William H	Delaware
WILKOS, MD, Francis J	Erie
WILLARD, Douglas F	Students
WILLARD, MD, Samuel B	Bucks
WILLENS, MD, John S	Chester
WILLET, MD, Andrew Allen	Luzerne
WILLIAMS, MD, A Claude	Lycoming
WILLIAMS, MD, Barbara J	Montgomery
WILLIAMS, MD, Brenda A	Allegheny
WILLIAMS, MD, Burton L	Delaware
WILLIAMS, MD, Charles R	Adams
WILLIAMS, MD, Claude M	Delaware
WILLIAMS, MD, David O	Lehigh
WILLIAMS, MD, Edward D	Franklin
WILLIAMS, MD, F Marian	Philadelphia
WILLIAMS, MD, Glenn L	Philadelphia
WILLIAMS, MD, Henry N	Lancaster
WILLIAMS, MD, Herman J	Berks
WILLIAMS, MD, John J	Berks
WILLIAMS, MD, John T	Philadelphia
WILLIAMS, MD, Karl E	Allegheny
WILLIAMS, MD, Kirkley R	Philadelphia
WILLIAMS, MD, Leon R	Allegheny
WILLIAMS, MD, Melvin C	Indiana
WILLIAMS, MD, Norman S	Westmoreland
WILLIAMS, MD, R Hallock	Montgomery
WILLIAMS, MD, Richard A	Erie
WILLIAMS, MD, Richard G	Allegheny
WILLIAMS, MD, Robert H	Lycoming
WILLIAMS, MD, Robert W	Allegheny
WILLIAMS, MD, Scott L	Allegheny
WILLIAMS, MD, Stephen K	Montgomery
WILLIAMS, MD, Susan L	Delaware
WILLIAMS, MD, Victor A	Allegheny
WILLIAMS, MD, Virginia M	Dauphin
WILLIAMS III, MD, Irving	Union
WILLIAMS JR, MD, Gomer T	Bucks
WILLIAMS JR, MD, Kenneth H	Montgomery
WILLIAMS JR, MD, Philip D	Allegheny
WILLIAMS JR, MD, Thomas L	Northampton
WILLIAMSON, MD, Edward L	Westmoreland
WILLIAMSON, MD, Mark E	Allegheny
WILLIAMSON, MD, Neihl J	Lycoming
WILLIG, MD, Doris	Philadelphia
WILLIHNGANZ, MD, Walter D	Montgomery
WILLIS, MD, Bernard J	Lackawanna
WILLIS, MD, Johnnie S	Northampton
WILLISON, MD, Robert W	Allegheny
WILLNER, MD, David L	Chester
WILLWERTH, MD, James W	Berks
WILSKER, MD, Herbert B	Lancaster
WILSON, MD, Arthur R	Armstrong
WILSON, MD, Charles R	Allegheny
WILSON, MD, Donald F	Chester
WILSON, MD, Dorothy G	Northumberland
WILSON, MD, Frederick S	Montgomery
WILSON, MD, George M	Philadelphia
WILSON, MD, George W	Allegheny
WILSON, MD, James A	Lancaster
WILSON, MD, James L	Tioga
WILSON, MD, Janet L	Philadelphia
WILSON, MD, John F	Philadelphia
WILSON, John S	Students
WILSON, MD, John S	Westmoreland
WILSON, MD, Lance B	Bucks
WILSON, MD, Linda C	Chester
WILSON, MD, Ray A	York
WILSON, MD, Raymond N	Westmoreland
WILSON, MD, Richard A	Armstrong
WILSON, MD, Richard C	Lehigh
WILSON, MD, Richard P	Philadelphia
WILSON, MD, Robert J	Allegheny
WILSON, MD, Roma A	Delaware
WILSON, MD, Ruth W	Beaver
WILSON, MD, Steven H	Greene
WILSON, MD, Thomas W	Lawrence
WILSON, MD, Walter N	Allegheny
WILSON, MD, William L	Allegheny
WILSON, MD, William W	Montgomery
WILSON JR, MD, Robert N	Montgomery
WILT, MD, John W	Bradford
WILT, MD, Kenneth E	York
WILTON, MD, Edward A	Montgomery
WIMSATT, MD, Michael H	Mifflin/Juniata
WINANS, MD, Lewis E	Berks
WINARD, MD, Sue H	Philadelphia
WINEGRAD, DO, Leonard	Philadelphia
WINER, MD, Stephen F	Lebanon
WINEY, MD, Wilfred H	Cambria
WINFREE, MD, Listervelt	Philadelphia
WING, MD, Edward J	Allegheny
WINGARD, MD, Larry B	Armstrong
WINGERD, MD, Robert A	Franklin
WINGERT JR, MD, Charles H	Centre
WINGERT JR, MD, J Paul	Blair
WINHELD, MD, Edward B	Philadelphia
WINIARSKI, MD, Genevieve C	Lancaster
WINIARSKI, MD, Janusz	Blair
WINKLER, MD, Martin	Allegheny
WINKLER JR, MD, Louis H	Northampton
WINN, MD, Charles	Delaware
WINN, MD, Randall S	Berks
WINN JR, MD, Charles L	Bucks
WINSKI, MD, Leonard A	Columbia
WINSLOW, MD, Roy E	Beaver
WINSON, MD, Samuel G	Philadelphia
WINSTANLEY, MD, Robert A	Cambria
WINSTEAD, MD, Welby	Bradford
WINSTON, MD, James R	Philadelphia
WINSTON, MD, Joseph M	Berks
WINSTON, MD, Norman J	Berks
WINSTON, MD, Ralph B	Bradford
WINT, MD, Samuel J	Cambria
WINTER, MD, Charles R	Lancaster
WINTER, MD, Fred S	Montgomery
WINTER, MD, Mark S	Montgomery
WINTER, MD, Peter M	Allegheny
WINTER 2ND, MD, John C	Lycoming
WINZELBERG, MD, Gary G	Allegheny
WIRE, MD, Wilbur H	York
WIRTS JR, MD, C Wilmer	Philadelphia
WISE, MD, Richard J	Luzerne
WISEMAN, MD, Barbara L	Philadelphia
WISEMAN, DO, Douglas C	Northampton
WISEMAN, MD, Jeffrey S	Philadelphia
WISHNEV, MD, Martin A	Allegheny
WISNESKI JR, MD, John T	Allegheny
WISNIEWSKI, MD, Peter M	Philadelphia
WISS, MD, Raymond J	Cumberland
WISSINGER, MD, H Andrew	Allegheny
WISSLER, MD, Robert U	Lancaster
WITHAM, Nancy D	Students
WITHERSPOON, MD, John S	Allegheny
WITHERSPOON, MD, Robert G	Westmoreland
WITKIN, MD, Evelyn D	Montgomery
WITKOWSKI, MD, Joseph A	Philadelphia
WITMER, MD, Donald B	Lancaster
WITMER, MD, Robert H	Lancaster
WITOWSKI, MD, John J	Lackawanna
WITT, MD, D Ernest	Columbia
WITT, MD, Paul J	Luzerne
WITTELS, MD, Emanuel	Berks
WITTHOFF JR, MD, Elmer M	Lycoming
WITTIG, MD, Robert L	Allegheny
WITTMAN, MD, Paul C	Philadelphia
WITTMANN, MD, Thomas A	Erie
WODNICKI, MD, Moises	Washington
WOERTHWEIN, MD, Kenneth F	York
WOHL, Daniel L	Students
WOHL, MD, Milton A	Philadelphia
WOJCIAK, DO, Raymond J	Allegheny
WOJTOWYCH, MD, Mykola	Philadelphia
WOLANIN, MD, Janusz	Luzerne
WOLBACH JR, MD, Albert B	Lancaster
WOLDORF, MD, Norman M	Dauphin
WOLDOW, MD, Andrew B	Montgomery
WOLDOW, MD, Asher	Philadelphia
WOLDOW, MD, Irving	Philadelphia
WOLF, MD, Charles R	Chester
WOLF, MD, Franklin M	Berks
WOLF, MD, Lewis R	Philadelphia
WOLF, MD, Melinda J	Allegheny
WOLF, MD, Melvin A	Montgomery
WOLF, MD, Sandra M	Philadelphia
WOLF, MD, Stephen H	Bucks
WOLF, MD, Stewart G	Northampton
WOLF JR, MD, John H	Philadelphia
WOLFE, MD, Daniel E	Lycoming
WOLFE, MD, Dwight D	Lancaster
WOLFE, MD, Patrick W	Cambria
WOLFE, MD, William F	Dauphin
WOLFERTH JR, MD, Charles C	Philadelphia
WOLFF, MD, Bruce R	Mercer
WOLFF, MD, Charles R	Allegheny
WOLFF, MD, Jeffrey M	Allegheny
WOLFF, MD, Regis A	Allegheny
WOLFGANG, MD, Gary L	Montour
WOLFINGER, MD, Walter L	Franklin
WOLFORD, MD, Jack A	Allegheny
WOLFSON, MD, Bernard	Allegheny
WOLFSON, David H	Allegheny
WOLFSON, MD, Philip J	Philadelphia
WOLFSON, MD, Robert J	Philadelphia
WOLFSON JR, MD, Sidney K	Allegheny
WOLGEMUTH JR, MD, John M	Lancaster
WOLGIN, MD, William	Philadelphia
WOLINSKY, MD, Arthur P	Allegheny
WOLK, MD, Larry A	Philadelphia
WOLK, MD, Melvyn H	Lackawanna
WOLK, Michael D	Allegheny
WOLK, MD, Stephen M	Philadelphia
WOLK, MD, Thomas A	Chester
WOLLMAN, MD, Harry	Philadelphia
WOLLMAN, MD, Michael R	Allegheny
WOLMARK, MD, Norman	Allegheny
WOLOSHIN, MD, Henry J	Philadelphia
WOLSON, MD, Alan H	Lehigh
WON, MD, Kwan H	Dauphin
WON, MD, Okhee	Lackawanna
WONG, MD, Albert	Somerset
WONG, MD, Alfonso Ming Y	Philadelphia
WONG, MD, Hon Yuen	Clarion
WONG, MD, James	Berks
WONG, MD, James S	Philadelphia
WONG, MD, Ling G	Centre
WONG, MD, Ming-Der	York
WONGPAKDEE, MD, Sobsan	Potter
WONSETTLER, MD, Donald E	Mercer
WOOD, MD, Beverly A	Dauphin
WOOD, MD, Bradford J	Cumberland
WOOD, MD, David W	Montgomery
WOOD, MD, Ernest M	Lancaster
WOOD, MD, Francis C	Philadelphia
WOOD, MD, Howard P	Montgomery
WOOD, MD, John M	Allegheny
WOOD, Margaret D	Students
WOOD, MD, Margaret G	Philadelphia
WOOD, MD, Marlene B	Luzerne
WOOD, MD, Mary E	Adams
WOOD, MD, William E	Montour
WOODCOCK, MD, Charles H	Union
WOODCOCK, MD, Charles W	Dauphin
WOODINGS, MD, Samuel G	Mercer
WOODLEY, MD, Christopher C	Lackawanna
WOODMAN, MD, Thomas J	Bucks
WOODRING, MD, Albert J	Montgomery
WOODRING, MD, Leonard R	Berks
WOODRUFF, MD, Charles L	Philadelphia
WOODRUFF, MD, Frieda W	Montgomery
WOODRUFF, MD, Stephen M	Philadelphia
WOODRUFF JR, MD, D Stratton	Montgomery
WOODS, MD, Anne M	York
WOODS, MD, Lon D	Adams
WOODSIDE, MD, John A	York
WOODSON, MD, Cheryl E	Philadelphia
WOODWARD, MD, Edward G	Dauphin
WOOLLEY JR, MD, Paul O	Centre
WOOLSLAYER, MD, Paul R	Somerset
WORLEY, MD, Carl M	Allegheny
WORNAS, MD, Christian G	Berks
WOROBEC, MD, Russell N	Lycoming
WORRALL, MD, V Thomas	Allegheny
WORRILOW, MD, Suzanne H	Lebanon
WORSHTIL, MD, Mark E	Washington
WORTHINGTON, MD, John J	Montgomery
WOTRING, MD, John M	Berks
WOYNAROWSKI, MD, John A	Berks
WOZNIAK, MD, John	Delaware
WRIGHT, Bruce A	Allegheny
WRIGHT, MD, David G	Allegheny
WRIGHT, MD, David L	Venango
WRIGHT, MD, Eleanore R	Chester
WRIGHT, MD, F Malcolm	York
WRIGHT, MD, Kenneth C	Allegheny
WRIGHT, MD, L Alan	Allegheny
WRIGHT, MD, Lance S	Philadelphia
WRIGHT, MD, Merja T	Erie
WRIGHT, MD, Rayford E	Cambria
WRIGHT, MD, Richard E	Allegheny
WRIGHT, MD, Robert E	Lackawanna
WRIGHT, Ron	Students
WRIGHT, MD, Scott H	Philadelphia
WRIGHT, MD, Thomas S	Montgomery
WRIGHT, MD, William C	Columbia
WRIGHT, MD, William R	Lawrence
WRIGHT JR, MD, Alfred E	Fayette
WRIGHT JR, MD, George C	Allegheny
WRIGHT JR, MD, George J	Allegheny
WROBLESKI, MD, Harry F	Allegheny
WU, MD, Chau H	Elk/Cameron
WU, MD, Chung H	Philadelphia
WU, MD, Jung-Yi	Lackawanna
WULC, MD, Allan E	Montgomery
WUMMER, MD, Brian A	Berks
WUNDERLICH JR, MD, J Andreas	Allegheny
WURTELE, MD, Lester H	Philadelphia
WUSTROW, MD, H Juergen	Blair
WUSYLKO, MD, Michael	Allegheny
WYMER, MD, Ralph M	Butler
WYNERT, MD, William R	Cambria

X

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XAVIER, MD, Cherian P	Philadelphia

Y

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YAMASHITA, MD, Takeo	Lehigh
YAMULLA, MD, Stanley J	Luzerne
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YANG, MD, Jau-Hsin	Allegheny
YANG, MD, Shuin-Lin	Philadelphia
YANG, MD, Un-Taek	Montgomery
YANG, MD, Wen-Shiong	Lehigh
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YANNACCONE, MD, Robert	Union
YANOFF, MD, Myron	Philadelphia
YANOFSKY, MD, Charles S	Dauphin
YANOSHAK, DO, Robert N	Luzerne
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YARNALL, MD, G Winfield	Dauphin
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YARROW, MD, Morris W	Philadelphia
YARTZ, DO, Frank C	Montour
YASGUR, MD, Lee H	Philadelphia
YASHARI, MD, Manoochehr	Montgomery
YASKIN, MD, Hyman E	Philadelphia
YASUI, MD, Robert S	Lycoming
YASWINSKI JR, MD, Peter T	Monroe
YATES, MD, Adolph J	Allegheny
YATES, MD, Anthony P	Allegheny
YATES, MD, James A	Dauphin
YATES, MD, William A	Cambria
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YAZDANFAR, MD, Shahriar	Philadelphia
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YEAGER, MD, James P	Cumberland
YEAGLEY, MD, Heber E	Berks
YEAKEL, MD, Allen E	Lancaster
YEALY, MD, W Holmes	Lycoming
YEAMANS, MD, Bruce E	Lebanon
YEASTED, MD, G Alan	Allegheny
YEAW, MD, Scott C	Northampton
YELLENIK, MD, Andrew C	Allegheny
YEN, MD, Conception T	Lehigh
YEOMAN, MD, Margaret P	Delaware
YERGER, MD, John F	Cambria
YESKEY, MD, Kevin S	Dauphin
YEVITZ, MD, Michael G	Lackawanna
YEVITZ, MD, William J	Lackawanna
YING, MD, Shun C	Allegheny
YINGLING, MD, Nathaniel D	Clearfield
YINGVORAPANT, MD, Somchao	Allegheny
YIP, MD, Luke C	Lehigh
YOCKEY, MD, Robert H	Armstrong
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YOCUM, DO, Martin D	Lebanon
YODER, MD, John B	Lancaster
YODER, MD, Morris L	Delaware
YODER, MD, Stanley J	Centre
YOH, MD, Harold N	Berks
YOHE, MD, Frank J	Allegheny
YOHE, MD, William C	York
YONAS, MD, Howard	Allegheny
YOO, MD, Eun S	Lackawanna
YOO, MD, Ho Joon	Erie
YOO, MD, Hoon	Wayne/Pike
YOO, MD, Tai Y	Jefferson
YOON, MD, Chan	Lycoming
YOON, MD, Chung H	Philadelphia
YOON, MD, Donald D	Westmoreland
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YOST, MD, Charles S	Columbia
YOST, MD, Robert M	Montgomery
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YOUNDT, MD, Luke B	Berks
YOUNES, MD, Mamdouh S	York
YOUNG, MD, Cheng Dong	Allegheny
YOUNG, MD, Geraldine P	Philadelphia
YOUNG, MD, Henry A	Erie
YOUNG, MD, In Min	Montgomery
YOUNG, MD, Irving	Philadelphia
YOUNG, MD, J Michael	Lancaster
YOUNG, MD, James F	Lancaster
YOUNG, MD, James L	Allegheny
YOUNG, MD, John J	Lehigh
YOUNG, MD, Joseph M	Westmoreland
YOUNG, MD, Lionel W	Allegheny
YOUNG, Michelle P	Allegheny
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YOUNG, DO, William E	Centre
YOUNG, MD, William W	Lancaster
YOUNG EXEC, DIR, Sherwood C	Berks
YOUNGBERG, MD, Russell E	Berks
YOUNGKIN, MD, James F	Columbia
YOUNGWIRTH, MD, Lewis D	Bradford
YOURD, MD, Raymond A	Mercer
YOUSHAW, MD, Dennis G	Blair
YOW, MD, Michael V	Delaware
YOXTHEIMER, MD, Robert L	Chester
YU, MD, Leonard T	Philadelphia
YU, MD, Paul T	Northampton
YUCHA, MD, Thomas J	Dauphin
YUDIS, MD, Melvin	Montgomery
YUKEVICH, MD, John P	Beaver
YUM, MD, Keuk Y	Delaware
YUMANG, MD, Norberto Y	Lawrence
YUMEN, MD, Omar	Montour
YUN, MD, Daniel D	Philadelphia
YUN, MD, Jae K	Erie
YUN, MD, Won K	Lebanon

Z

ZABALA-OMBAO, MD, Lourdes A	Philadelphia
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ZABLOTSKY, MD, Peter M	Butler
ZACCARDI, MD, James P	Allegheny
ZACHIAN, MD, Victor A	Philadelphia
ZADECKY, MD, Leonard B	Washington
ZADEH, MD, Habib T	Somerset
ZADEH, MD, Mehdi L	Erie
ZAEPFEL, MD, Joseph P	Lancaster
ZAFAR, MD, Ghaffar A	Schuylkill
ZAFAR, MD, Syed A	Allegheny
ZAFAR, MD, Tasneem S	Washington
ZAGER, MD, Ruth P	Philadelphia
ZAGURSKY, MD, Joyce A	Delaware
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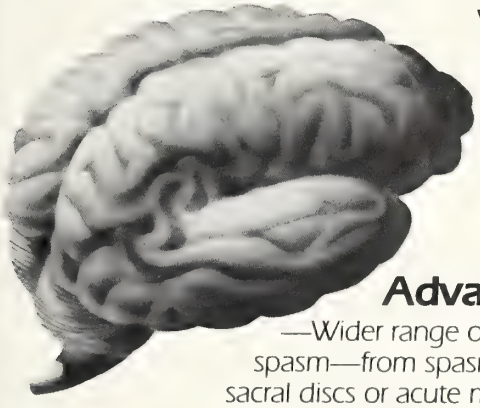
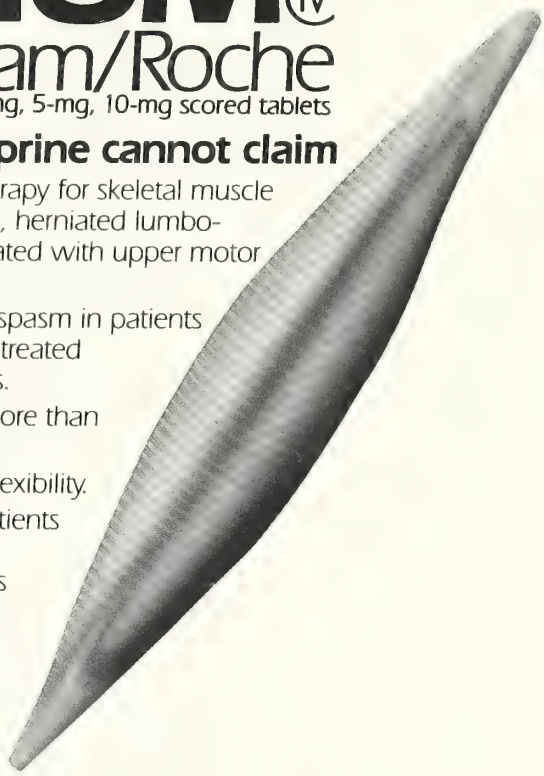
ZAIDAN, MD, James G	Fayette
ZAINO, MD, Richard J	Dauphin
ZAITOON, MD, Mohammad M	Westmoreland
ZAJAC, MD, Barbara A	Montgomery
ZAJAC, MD, Christopher J	York
ZAK, Paula M	Allegheny
ZAKHARY, MD, George	Schuylkill
ZAKRESKI, MD, Matthew J	Philadelphia
ZALADONIS, MD, Joseph J	Lehigh
ZALADONIS, MD, Sylvia P	Lehigh
ZALAMEA, MD, Petronio F	Beaver
ZALATIMO, MD, Akram A	Luzerne
ZALE, MD, Anthony G	Lackawanna
ZALMAN, Richard	Students
ZAMBARANO, MD, Thomas J	Dauphin
ZAMBELLI JR, MD, George R	Beaver
ZAMMERILLA, MD, Charles A	Fayette
ZAMOSTIEN, MD, Bernard B	Philadelphia
ZAMOSTIEN, MD, Paul S	Delaware
ZANGRILLI, MD, James G	Allegheny
ZANGWILL, MD, Donald P	Allegheny
ZANKMAN, MD, Nathan	Bucks
ZANNI, MD, Anthony L	Bucks
ZAPATA, MD, William A	Berks
ZAPP, John J	Allegheny
ZAPPACOSTA, MD, Frank H	Philadelphia
ZARATE, MD, Maria Paz A	Greene
ZAREN, MD, Howard Allen	Philadelphia
ZARFOS, MD, Morgan L	York
ZASLOW, MD, Jerry	Philadelphia
ZATUCHNI, MD, Jacob	Philadelphia
ZAVAHIR, MD, M Feizal	Blair
ZAYDON, MD, Anne C	Lackawanna
ZDERIC, MD, Stephen A	Philadelphia
ZEBROWSKI, MD, Mitchell E	Philadelphia
ZECCARDI, MD, Joseph A	Philadelphia
ZEE, MD, Mary K	Delaware
ZEGEL, MD, Harry G	Philadelphia
ZEGLEN, MD, Arthur F	Philadelphia
ZEHEL, MD, Wendell E	Allegheny
ZEHNER, MD, Luther R	Crawford
ZEHR, MD, Ralph D	Bradford
ZEIGERMAN, MD, Joseph H	Philadelphia
ZEIGLER, MD, David C	Centre
ZEIGLER JR, MD, Maurice L	Dauphin
ZEILER, MD, William B	Allegheny
ZEIT, MD, Robert M	Philadelphia
ZEITLIN, MD, Mark H	Erie
ZEITLIN, MD, Warren M	Montgomery
ZELEN, MD, Randy S	Crawford
ZELESNICK, MD, Gabriel	York
ZELEZNIK, MD, Miroslav	Westmoreland
ZELEZNOCK, MD, William A	Allegheny
ZELINKA, MD, Maureen A	Dauphin
ZELIS, MD, Robert F	Dauphin
ZELKOVIC, MD, Audrey A	Allegheny
ZELLER, MD, Donald J	Allegheny
ZELLER, MD, Erwin R	Chester
ZELLER, MD, Harry R	Allegheny
ZELLER, MD, Robert G	Lycoming
ZELLEY, MD, Lee S	Montgomery
ZELLIS, DO, Joseph	Philadelphia
ZELNICK, MD, Eric B	Berks
ZELT, MD, Roger P	Allegheny
ZEMBLE, DO, Herbert A	Philadelphia
ZEMEL, MD, Gerald	Allegheny
ZEMEL, MD, Reuben	Allegheny
ZEMO, MD, Peter L	York
ZENOUZI, MD, Sirus	Bucks
ZERBE, MD, Grover F	Dauphin
ZERBY, MD, Jeffrey C	Berks
ZERITSKY, MD, Samuel A	Philadelphia
ZERNE, MD, G Edward	Chester
ZERNICH, MD, Michael R	Beaver
ZERNICH, MD, Milas	Allegheny
ZERNICH, MD, Wallace	Beaver
ZERNICH JR, MD, Stephen	Beaver
ZERVANOS, MD, Nikitas J	Lancaster
ZERVOS, MD, Denis G	Philadelphia
ZEVENEY JR, MD, Dennis J	Luzerne
ZIBELMAN, MD, Mark	Delaware
ZIDO, MD, Albert J	Allegheny
ZIEDONIS, Douglas M	Students
ZIEGENFUS, MD, William D	Delaware
ZIEGLER, MD, Anna M	Lehigh
ZIEGLER, MD, Jay M	Washington
ZIEGLER, MD, Moritz M	Philadelphia
ZIEGLER, MD, Richard W	Philadelphia
ZIELINSKI, MD, Richard F	Montour
ZIENTEK, MD, Leon T	Berks
ZIERDT, MD, David K	Cumberland
ZIEZIULA, MD, Ronald F	Erie
ZIGERMAN, DO, Herbert L	Philadelphia
ZIGROSSI, MD, Richard J	Allegheny
ZIKRIA, MD, Emir A	Allegheny
ZIMET, MD, Daniel L	Chester
ZIMM, MD, Edward J	Erie
ZIMMER, MD, Ben	Allegheny
ZIMMER, MD, Cynthia S	Montour
ZIMMER, MD, Frederick E	Montour
ZIMMERMAN, MD, A Leonard	Blair
ZIMMERMAN, MD, Charles W	Allegheny
ZIMMERMAN, MD, David S	Dauphin
ZIMMERMAN, MD, Edward M	Beaver
ZIMMERMAN, MD, Karl	Allegheny
ZIMMERMAN, MD, Marc S	Philadelphia
ZIMMERMAN, MD, Mark	Bradford
ZIMMERMAN, MD, Richard P	Cambria
ZIMMERMAN, MD, Robert A	Philadelphia
ZIMMERMAN, MD, Ronald L	Allegheny
ZIMMERMAN JR, MD, Franklin D	Lebanon
ZIMMERMANN, MD, Albert W	Montgomery
ZIMRING, MD, David	Philadelphia
ZINNAMOSCA, DO, John B	Crawford
ZINOBILE, MD, Anthony J	Washington
ZINSSER, MD, Kendall R	Lebanon
ZINSSER, MD, Michael H	Washington
ZINTL, MD, William J	Delaware
ZIOBROWSKI, MD, Frank G	Franklin
ZISCHKAU, MD, Douglas D	Berks
ZISELMAN, MD, Ethel M	Chester
ZISERMAN, MD, Abraham J	Philadelphia
ZISKIND, MD, Zelda	Allegheny
ZITELLI, MD, John A	Allegheny
ZITNER, MD, George L	Allegheny
ZLUPKO, MD, George M	Blair
ZNOY, MD, Josesph M	Allegheny
ZOBEL JR, MD, Arthur C	Lackawanna
ZOBIAN, MD, Edward J	Berks
ZOGHLIN, MD, Benson L	Allegheny
ZOLFAGHARI, MD, Roknedin	Philadelphia
ZOLGHADRI, MD, Siavash	Berks
ZOLLER, MD, Mary A	Montgomery
ZONE, MD, Donald D	Erie
ZORUB, MD, David S	Allegheny
ZUBCHEVICH, MD, Emira D	Fayette
ZUBKIN, MD, Allan	Bucks
ZUBKOFF, MD, Gerald N	Philadelphia
ZUBRITZKY, MD, Paul M	Allegheny
ZUBRITZKY, MD, Stephen A	Allegheny
ZUBROW, MD, Sidney N	Philadelphia
ZUCK, MD, Walter N	Westmoreland
ZUCKER, MD, Eli W	Montgomery
ZUCKERMAN, MD, Gilbert L	Philadelphia
ZUCKERMAN, MD, Nathan	Bucks
ZUG, MD, P Ronald	Union
ZUKOSKI, MD, Joseph T	Montgomery
ZUKOSKI, MD, Thomas E	Lackawanna
ZULICK JR, MD, Thomas C	Northampton
ZUROWESTE II, MD, Edward L	Franklin
ZVARGULIS, MD, Janis E	Philadelphia
ZWEIG, MD, Neal	Allegheny
ZWEIZIG, MD, Helen Z	Philadelphia
ZWERLING, MD, Hermann	Schuylkill
ZWERLING, MD, Israel	Philadelphia
ZWILLENBERG, MD, David A	Philadelphia

THE SPASM/PAIN/SPASM CYCLE

In skeletal muscle spasm due to local pathology, responsive to the distinct actions of



Adjunctive
VALIUM® (IV)
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets



Advantages cyclobenzaprine cannot claim

—Wider range of indications as adjunctive therapy for skeletal muscle spasm—from spasm due to local pathology (*e.g.*, herniated lumbosacral discs or acute muscle strain) to spasm associated with upper motor neuron disorders (*e.g.*, cerebral palsy and paraplegia).

—May be used adjunctively for relieving skeletal muscle spasm in patients with hyperthyroidism, cardiac patients and patients being treated with anticholinergics or guanethidine-type antihypertensives.

—Can be administered to patients less than 15 years and more than 6 months of age.

—Scored tablets in three strengths provide greater dosage flexibility.

Since drowsiness, fatigue and ataxia sometimes occur, patients should be cautioned against driving or operating hazardous machinery and should also be advised against simultaneous ingestion of alcohol.

References: 1. Rankin EA: *Contin Educ 3*(1):46-50, Jan 1975. **2.** When muscle spasm hobbles your patient. *Patient Care 8*(11):20-37, Jun 1, 1974.

Valium® (diazepam/Roche) (IV)
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not as sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension; changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence; changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults.* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients.* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, round, scored tablets with a cut out "V" design—2 mg, white; 5 mg, yellow; 10 mg, blue— bottles of 100 and 500; Prescription Paks of 50, available in trays of 10. Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10.

Imprint on tablets
2 mg—2 VALIUM® (front)
ROCHE (scored side)

5 mg—5 VALIUM® (front)
ROCHE (scored side)

10 mg—10 VALIUM® (front)
ROCHE (scored side)

ROCHE®
ROCHE PRODUCTS INC
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Pennsylvania Medicine

Volume 88, No. 9 SEPTEMBER 1985

Also in this issue:
Medigram—page 9
Outline of PR proposal—page 21

The Surgeon as Writer

The Last Grand Rounds of Richard Selzer

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flurazepam HCl/Roche ⓒIV

sleep that satisfies

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References: **1.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **2.** Kales A, Kales JD: *J Clin Psychopharmacol 3*:140-150, Apr 1983. **3.** Tennant FS, *et al*: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. **4.** Kales J, *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **5.** Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **6.** Kales A, *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982 **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC, *et al*: *Behav Med*, pp. 25-31, Oct 1978.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.
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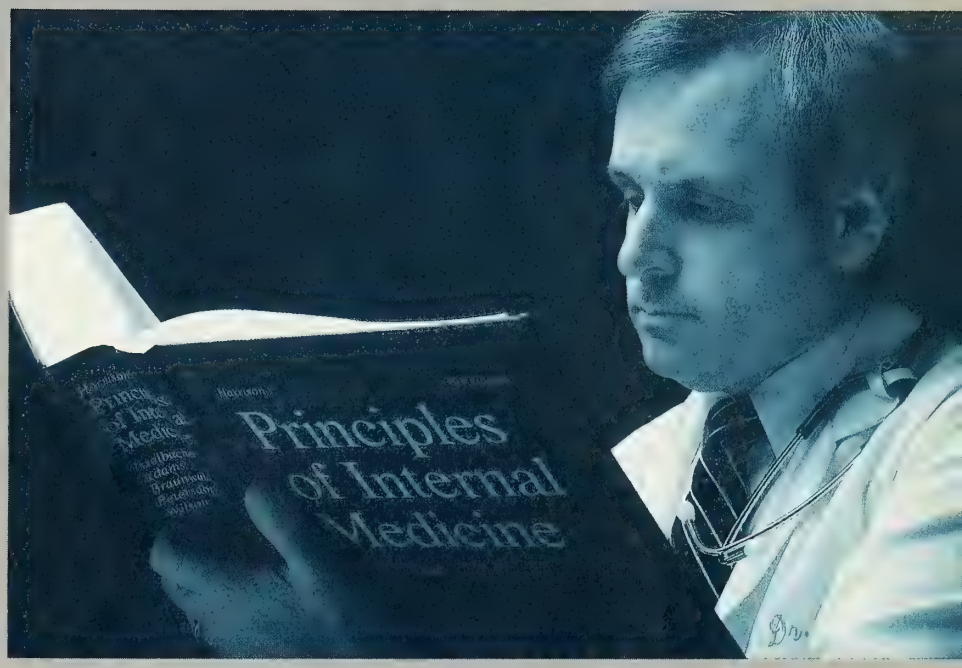

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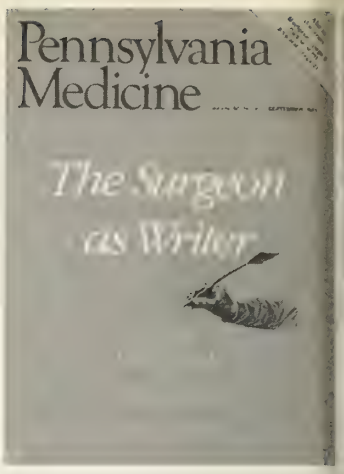

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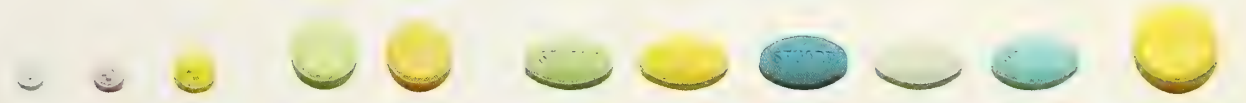

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Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg, for chewable tablets, 5 mg, for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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medigram

DR. TYSON GIVES PMS POSITION AT HOUSE COMMITTEE HEARINGS

R. Robert Tyson, MD, PMS vice president, testified at three consecutive days of public hearings on proposed legislation on health care cost containment (see "Capital Commentary," page 40). Chairman James D. Barber of the House Health and Welfare Committee divided the hearings by subject matter. On August 20, testimony was limited to uncompensated care as a health care cost containment strategy. Data collection and disclosure was the subject on August 21, and utilization review was addressed on August 22. A fourth day of testimony, limited to comments on capital cost controls, is scheduled for September 11 at the Lehigh Valley Hospital Center, Allentown. Details will appear in the October issue.

HOUSE OF DELEGATES MEETS OCTOBER 25 IN PHILADELPHIA

The 1985 meeting of the Society's House of Delegates will be at the Bellevue Stratford Hotel, Philadelphia, from Friday, October 25 through Sunday, October 27. Reference Committee hearings, which are open to all members, will take place on Friday afternoon. The installation of R. William Alexander, MD, of Reading, as 136th president, will occur at 6:00 p.m., October 26. All resolutions should be submitted to the Office of the Secretary. Resolutions submitted before September 25 automatically become the business of the House. Resolutions submitted after that deadline require a two-thirds vote to be accepted as House business. Those submitted after the House convenes at 10 a.m. Friday require the approval of three-fourths of the delegates to become House business. An explanation of the reasons for delay should accompany all late resolutions.

KePRO BEGINS REVIEW EFFORT, SEEKS PHYSICIANS AS ADVISORS

The Keystone Peer Review Organization (KePRO) has begun peer review of Medicare hospitalizations in Pennsylvania. In a letter to all physicians, Donald E. Harrop, MD, president, outlined KePRO's objectives and asked for the participation of physicians in the advisor program to conduct occasional review of cases. KePRO was awarded the $20 million contract to review hospitalizations under Medicare in July.

PMS INSURANCE COMPANY SEEKS RATE REVISIONS

The Pennsylvania Medical Society Liability Insurance Company has submitted rate and rule revisions for Insurance Department approval. Published in the Pennsylvania Bulletin August 10, the filing becomes effective October 1, 1985 unless department action is taken before August 31. The major proposals are: (1) A six-month freeze on premiums for insureds who have not reported any chargeable claims activity; (2) reduction of rates for certain specialties; and (3) establishment of a

multi-tiered rating system based on individual policyholders' loss experience. A majority of PMSLIC's over 6,000 insureds will have the same or reduced premiums. Where premium increases result, the amount will depend on the individual's loss experience.

GOVERNOR THORNBURGH APPOINTS ACTING INSURANCE COMMISSIONER

George F. Grode assumed the duties of acting insurance commissioner July 24, replacing William R. Muir Jr., who resigned in June. Grode has served in the Thornburgh administration in several other capacities, most recently as deputy secretary of policy and planning.

FOUNDATION AND PSU SPONSOR SEMINAR ON HMOs IN HERSHEY

The Pennsylvania Medical Care Foundation and the Pennsylvania State University College of Medicine will conduct a one-day seminar on Health Maintenance Organizations on Thursday, September 26, at the Hershey Country Club. For details, call PSU continuing education at (717) 534-6495.

HOSPITAL INSURER REQUESTS 45 PERCENT PREMIUM INCREASE

The Pennsylvania Casualty Company (PCC) has filed a premium increase request of 45 percent for hospital professional liability coverage and 6 percent for general liability coverage. Published in the Pennsylvania Bulletin August 3, the filing could produce approximately $7 million annually in additional income for the PHICO Group, of which PCC is a part.

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editorial

Institutions and risk management

Risk management is the process of identifying, evaluating, and rectifying risks that pose a financial hazard to institutions. Risk management also allows for improved quality of care by identifying, evaluating and controlling, or if possible eliminating, incidents that give rise to unplanned patient injury. Such incidents are unexpected occurrences that depart from normal routine and frequently, although not always, involve patients.

As one who falls, nor knows how the fit
comes
By diabolic power, or oppilation
That chokes the brain with stupefying
fumes,

Who, when he rises, stares in
consternation
All around, bewildered by his late hard
throes,
With rolling eyes and anguished
suspiration.

from Dante's *Divine Comedy*

Whether in the hospital, nursing home, or other institutional care setting, falls are the most common in-patient accidents, constituting probably 70 to 80 percent of patient incidents. Fortunately, only a small number of falls result in injuries severe enough to cause extended stays but prevention should be a goal. Institutional liability can be limited by adhering to acceptable standards of care and by exercising all possible precautions for patient safety.

Studies have shown that certain groups of patients are more likely to fall than others, and that circumstances of surroundings contribute significantly to falls. Some patients appear to be accident prone and having fallen once, are likely to do so again. Patients older than 65 years who are suffering from chronic diseases such as senile dementia or other disorders resulting in disorientation are a high-risk group. Patients who have multiple diagnoses or physical disabilities, particularly those involving muscle control or abnormalities of gait, are at risk for falls. Medications, especially those that interfere with perception, may cause falls. Sometimes elderly patients become disoriented simply because of the change in normal routine or environment; thus, many patient falls happen during the first week of a relocation. Visual acuity is another important factor in patient falls. Diminished night-time vision or unseen objects in normal walking pathways create additional problems for sight impaired patients.

Not only are the physical condition and mental state of the patient contributory, but outside factors are equally important. Foot stools at bedside, furniture in corridors, unstable chairs or tables, poorly fastened restraints, absence of secure hand-holds, and very high beds add to the likelihood of falls. Wheelchairs are involved in so many accidents that they should be considered probable risk factors. Slips and slides because of failure to use non-skid footwear are an important factor.

Since early ambulation of patients is increasingly prevalent, a certain number of falls must be expected. Movement is important to both physical and mental well-being and should not be limited or curtailed. Thus it is necessary to apply as many precautionary measures as possible. All personnel should be aware of the possible effects that their daily duties may have on patient safety. Clear corridors should be maintained. Unstable or broken furniture should be removed from patient care areas. Patients should be assisted with routine activities as necessary. The majority of falls occur in the patient's room or the adjacent bathroom. Adequate light should be provided at night when disorientation is likely to occur.

Patient falls will never be entirely eliminated. But patient safety can be improved by observing simple safety precautions and by adopting a watchful attitude. "If accidents happen and you are to blame, take steps to avoid repetition of same." Thus Dorothy L. Sayers pointed to the basic principle of risk management.

David A. Smith, MD
Medical Editor

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Rx for professional liability epidemic

Brenda P. Kozar

"An excellent service—helps to make the dues worth what they are."

"I am delighted that PMS is sponsoring this project for the membership. More power to PMS Risk Management in future projects."

"This should be very useful—we are not taught any of this in medical school."

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"Risk management programs should be promoted where possible to illustrate that the membership dues in organized medicine do provide benefits to members. Too often physicians choose not to join because they cannot see any tangible benefits."

Physicians wrote these introductory comments about the various services offered by the PMS Risk Management Department. PMS instituted its risk management program in January 1984. Recommended by the Society's Task Force to Study Professional Liability Insurance, the program was created to help physicians learn ways to manage risks and prevent suits.

Judith R. Brown, RN, JD, directs the PMS Risk Management Department. She also serves as vice president and director of risk management and loss prevention for the PMS Liability Insurance Company (PMSLIC). Brenda P. Kozar, administrative assistant, and Edith R. Cooper, risk management secretary, are on staff.

The risk management program was set up to provide physicians with information on how to practice legally safer medicine while delivering optimal patient care. In order to achieve this goal, the staff has developed varied educational projects for physicians, most of which carry Category I CME (continuing medical education) credit for participation.

The Program offering that is probably most familiar to physicians in Pennsylvania is *Patient Rx Newsletter.* The newsletter, initiated by the PMSLIC Risk Management Department, is now in its seventh year of publication. It is designed to alert physicians to pertinent medical-legal issues affecting the everyday practice of medicine.

The Medical-Legal Correspondence Course presents thirty malpractice cases that have been litigated to a conclusion. After each factual situation, multiple-choice questions based on the cases are posed. Answers are revealed in an analysis section, along with a discussion of the medical-legal concepts presented. Examinations cover the material in each section. Physicians who complete the course successfully are awarded 12 hours of Category I CME credit. To date, over 4,000 courses have been distributed to physicians in Pennsylvania.

The Case File is another home study program offered to physicians. There are three versions: the Medical Case File for medical specialty physicians; the Surgical Case File for surgical specialty physicians; and the Orthopedic Case File for orthopedic surgeons. Each case file presents a situation from a closed PMSLIC claim and points out medical-legal and risk management is-

The staff of the Risk Management Department is shown above. Standing from left are Donna M. Bettio, Jane L. Conley, Edith R. Cooper, and Brenda P. Kozar. Judith R. Brown, RN, JD, is seated. The staff members implement programs for both the Society and its liability insurance company.

The author is the administrative assistant for the PMS Risk Management Department.

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Total medical malpractice premium for physicians and hospitals in 1983 was estimated $3 billion dollars.

Source: American Medical Assurance Co.

sues raised by the case. There is an examination to be completed and returned for CME credit.

Videotapes are available and are loaned free-of-charge to interested physicians and groups. Using closed claims, the programs review risk management and medical-legal principles and offer practical actions physicians can take under similar circumstances to reduce the threat of malpractice suits. One of the videotapes specifically addresses the problems unique to the high-risk specialty of obstetrics and gynecology. The remainder of the tapes are suitable for physicians of all specialties.

The Pennsylvania Catastrophe Loss (CAT) Fund surcharge hit 70 percent in 1985, increased from 52 percent in 1984.

Source: CAT Fund, 1984 Annual Report

The department gives risk management presentations to groups of physicians on an ongoing basis. These groups include hospital medical staffs, resident groups, county medical society members, medical students, and specialty organization members.

An all-day seminar in Philadelphia, recently sponsored by the department, was evaluated favorably by the participants. Audiocassette tapes of the seminar were offered to interested PMS physicians. Over 5,000 society members took advantage of this free offer.

Currently, the staff is producing two videotapes: "Medical-Legal Issues for the Surgical Specialties" and "Medical-Legal Issues for the Medical Specialties." The videotapes, which will be available for distribution late this year, are being produced in response to survey results that indicated physicians are interested in this type of program.

It is impossible to measure the effect these services will have on reducing the number and frequency of malpractice claims filed; however, the physicians who have commented on the programs feel these education tools help to improve the quality of medical care.

In 1983 the CAT Fund paid $54,169,175 in claims payments. One year later, it paid out $66,777,096, an increase of 19 percent.

Source: CAT Fund, 1984 Annual Report

For more information about the PMS risk management program or any of its services, call 717-763-4750. □

The Pennsylvania Medical Society Liability Insurance Company (PMSLIC) currently is indexing over 100 files per month. In 1981, approximately 50 new claims and suits were being filed per month.

Source: Pennsylvania Medical Society Liability Insurance Company

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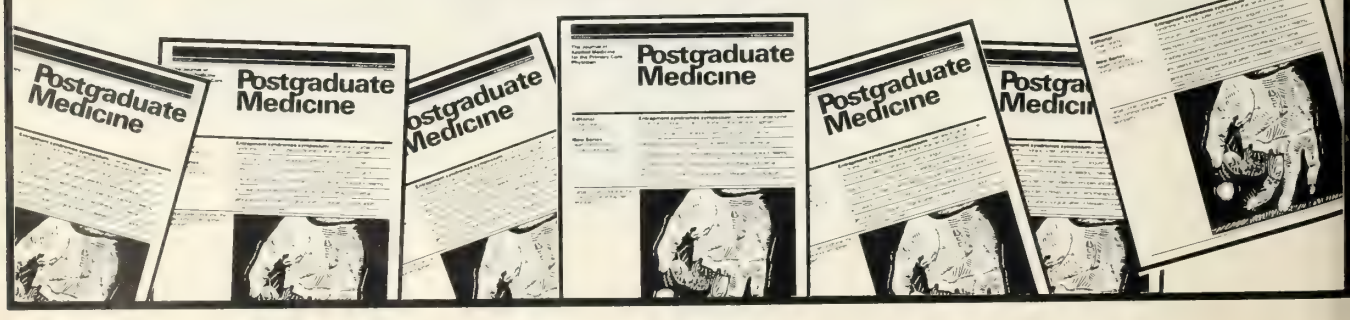

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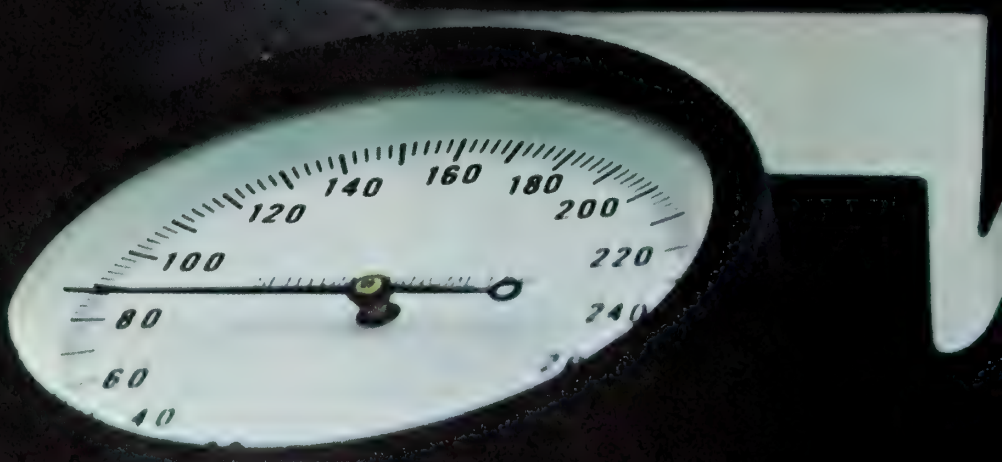

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Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

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For beta-1/beta-2 blockade

Once-daily INDERAL LA (PROPRANOLOL HCl)

80 mg 120 mg 160 mg

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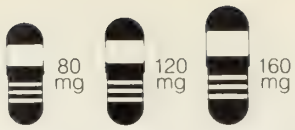
Please see brief summary of prescribing information on the next page for further details.

For beta-1/beta-2 blockade Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e g dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory bronchospasm

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768 **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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PR program aims to shift perceptions

Irving Williams III, MD

"Docs aren't the way they used to be. They don't care about their patients any more. They're just interested in making more money. Whatever the government does to doctors they deserve."

All of us have heard these statements. In recent years we have heard them with increasing frequency. And we in Pennsylvania aren't alone. These same comments are being heard throughout the nation. In reaction, physicians are beginning to realize that it's time to respond—and throughout the nation they are.

In Pennsylvania, in other states, and at the AMA, physician leaders have determined that organized medicine needs to be more aggressive in presenting points of view and positions which reflect accurately the image of a compassionate and caring profession, one which provides patients with their only advocates for quality health care. Activity in this direction began in Pennsylvania in September 1984, when the PMS Board established the Ad Hoc Committee on Public Relations.

The committee's charge was "to develop a public relations program for PMS to be presented to the Board of Trustees for its consideration." In its effort to fulfill this charge, the committee first reviewed the Society's public relations activities in recent years. Then it identified the goals of a public relations program. Recognizing that a comprehensive public relations campaign requires the assistance of an outside public relations counsel, the committee interviewed four public relations consultants and selected one. Finally, the committee identified the costs of the program.

Dr. Williams, PMS trustee representing the Sixth District, is chairman of the Ad Hoc Committee on Public Relations. He also is a leader in organized medicine at the county and national levels.

Approval from leaders, members

At the March 1985, meeting of the PMS Board, the Ad Hoc Committee presented its findings and recommended a program. After careful consideration, the Board unanimously endorsed the proposal, but, believing that a proposal of this magnitude should be taken to the full membership for its consideration, decided to poll the membership.

Early in May, PMS members received a letter and survey card from the Ad Hoc Committee on Public Relations. The letter briefly described the proposed PMS public relations campaign. The survey card asked members to indicate whether they agreed with the Board's endorsement of this program and if they would support a vote by their delegates at the 1985 House of Delegates to provide funds.

When results of this survey were tabulated, they indicated substantial support for the proposed program—76 per-

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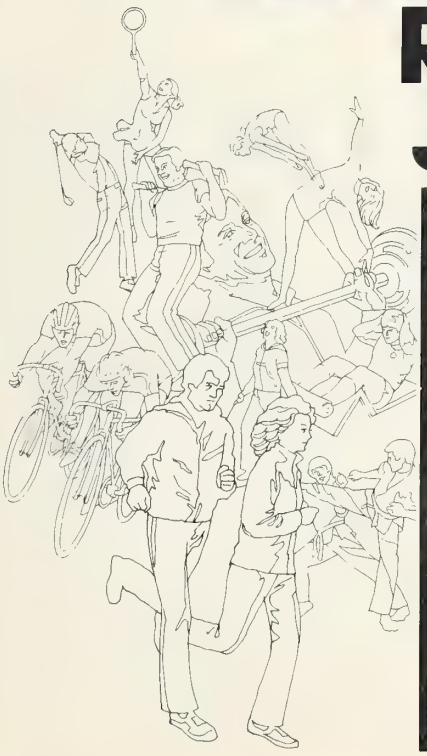

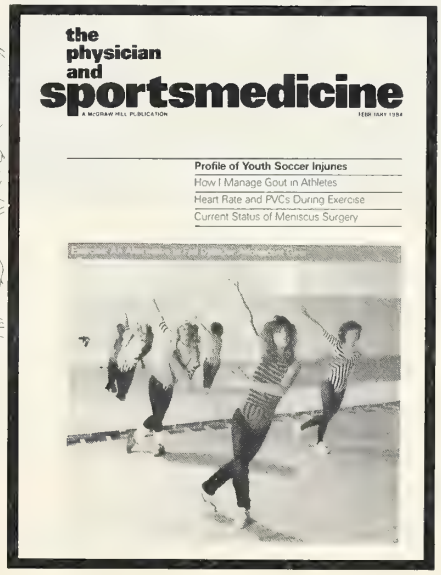

Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

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How I manage ingrown toenails.

cent voted yes to both questions, 18 percent voted no; and the remaining 6 percent fell into other categories.

Goals and objective

The major objective of the proposed program is *public education:*

- To give the public a better understanding of its stake in the changing health care system.
- To demonstrate the overriding concern physicians have for their patients as individuals and PMS has for patients in general.
- To indicate the necessity and beneficial effect of maintaining the physician's role as prominent decision-maker in the health care system.

To achieve this objective, the committee developed five program goals.

1. Address issues of public concern which do not directly affect physicians' interests but which portray physicians and PMS in a favorable light.

This might include such topics as:

- Cost of health care
- Toxic waste disposal
- Acid rain
- Mandatory use of seat belts
- Driving while intoxicated
- Wellness, fitness, and nutrition
- Mental health
- Teenage suicide
- Access to health care for the unemployed and poor
- Immunization

2. Portray physicians as patients' advocates concerned with maintaining quality care.

3. Publicize concerns and interests of Pennsylvania physicians on specific medical, social, and economic issues. Representative issues might be:

- Medical liability insurance reform
- Government and third-party imposed cost controls
- The expenditure of health care dollars

4. Improve physicians' perceptions of themselves along with the public's and the government's view of physicians by linking PMS membership with important public and professional issues.

5. Identify and suggest issues that PMS has taken a position on and has been active in pursuing or might pursue, and propose a plan of action to make known the Society's position and activities.

To help accomplish these goals, the public relations firm of Steigler & Wells of Allentown was selected. Their proposed three-year program consists of statewide television programming, radio spots, and newspaper and magazine advertising.

Measurement and multimedia

The strategy of their program is a statewide multimedia campaign whose purpose is to shift the public's perceptions of physicians and alter the direction of policies affecting medicine. This is to be done in three cost-effective phases over three years.

The program will begin with a measurement of the public's current attitudes, providing a base line against which to measure the effectiveness of the program's elements as it progresses.

Among the media to be utilized in the campaign is a customized 30-minute television program to be broadcast over the state's seven public television stations. In addition, public service announcements will be excerpted from these shows for distribution around the state.

Radio will be used in a similar way. Time will be bought for radio announcements throughout the state and, public service announcements will be sent to stations.

Print advertising will consist of newspaper advertising in the 12 largest markets in the state, and magazine advertising in the area editions of *Time, Newsweek, U.S. News and World Report,* and *Sports Illustrated.* The magazine campaign will consist of three black and white, one-page ads.

No free lunch

As Nobel Prize winning economist Milton Friedman says, "There is no free lunch." This is a comprehensive and substantial program, and its costs reflect this. The cost is $630,000 per year for a minimum of three years. All the consultants agreed that a program covering less than three years would be a waste of money. This equates to a cost of approximately $50 per year for each active, full dues paying member.

This proposal, because of its scope and expense, is expected to be a major focus of attention at the Society's Annual Business Meeting in Philadelphia, October 25-27, where final action will be in the hands of the House of Delegates. The committee expects that the House will share the sense of necessity and urgency for such an effort and the enthusiasm which the proposed program has engendered.

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Similar drug names may cause errors

Many drugs on the market today have similar spellings and pronunciations, but vastly different uses. This creates a potential for error that could have serious consequences. Jack B. Ogun, RPh, director of the state health department's division of drugs, devices, and cosmetics, said this problem was emphasized recently in a notification from Merrell Dow Pharmaceuticals.

"On May 20 of this year, Merrell Dow began marketing a new hayfever medication they have named Seldane. The company reports that as of July at least two prescriptions were mistakenly filled with a drug called Feldene, an arthritis medication that should be administered under close supervision because it can cause serious side effects.

"Although no serious injury was reported, the patients did not have the immediate benefit of the intended treatment and they were exposed to the risk of serious side effects from an unnecessary medication," Ogun said.

He said there are no statistics to indicate how many errors like this occur, but with more than 20,000 drug names on the market, at least 600 names are similar in spelling or pronunciation.

Some examples are: Demerol and Dymelor, Capastat and Cepastat, Ambenyl and Aventyl, Histex and Hiprex, Rifidin and Ritalin, Procaine and Procan, Terfonyl and Tofranil, Dilaudid and Dilantin, and a triple threat in Uracel, Uracil, and Uracid. There are hundreds more. Whose responsibility is it to reduce the chance for error? Ogun said it is everyone's responsibility—including the patient.

"When naming a drug, the pharmaceutical companies look for a name that is catchy, easy for the physician to remember, and easy to pronounce. With 20,000 drug names already in use it is difficult to come up with a name that meets their criteria, but the companies have a responsibility to choose a name that won't be confused with another drug," Ogun said.

"It is the physician's responsibility to be certain the name of the drug being prescribed is written clearly and correctly, along with some symptomatic indication on the purpose of the drug, such as "for pain," or "for congestion." It is the pharmacist's responsibility to dispense the correct drug. If there are any questions the pharmacist should check with the physician.

"Since the patient's health depends on the correct drug therapy, it is no less the patient's responsibility to be aware of the drugs they are using. As full participants in their own recovery, patients should want to know the name of the drug, what it is for, possible side effects, how it may react with other drugs, or with certain foods or beverages, when to take it, and when to discontinue the drug. If the physician and pharmacist do not offer the information the patient should ask for it, write it down and observe the recommendations," he said.

PMS Auxiliary honored at national convention

The Pennsylvania Medical Society Auxiliary (PMSA) was honored at the American Medical Association Auxiliary Convention for achievements in the areas of membership recruitment and communications.

PMSA was commended for achieving its "fair share"—an increase in members of more than ten percent, and for organizing a new county auxiliary—Clarion. In addition, the Society's auxiliary was recognized as the most outstanding state auxiliary in the country for showing the greatest increase in membership. PMSA also showed the greatest increase in AMA auxiliary members.

Keystone News, the auxiliary's publication, was named the best in the category of state magazines with a budget of more than $5,000. The magazine also was recognized as the most outstanding state auxiliary publication in the country.

At the 1985 meeting of the AMA Auxiliary, President Billie Brady presented a publication award to the Pennsylvania Medical Society Auxiliary for "most outstanding state auxiliary publication in the country." Receiving the award is Joyce West, left, PMSA president.

AMAA Membership Committee Chairman Norma Skoglund presented an award to the Pennsylvania Medical Society Auxiliary for the greatest numerical increase in AMA auxiliary members. Accepting the award are PMSA President Joyce West, left, and First Vice President and Membership Chairman Dee Lasher.

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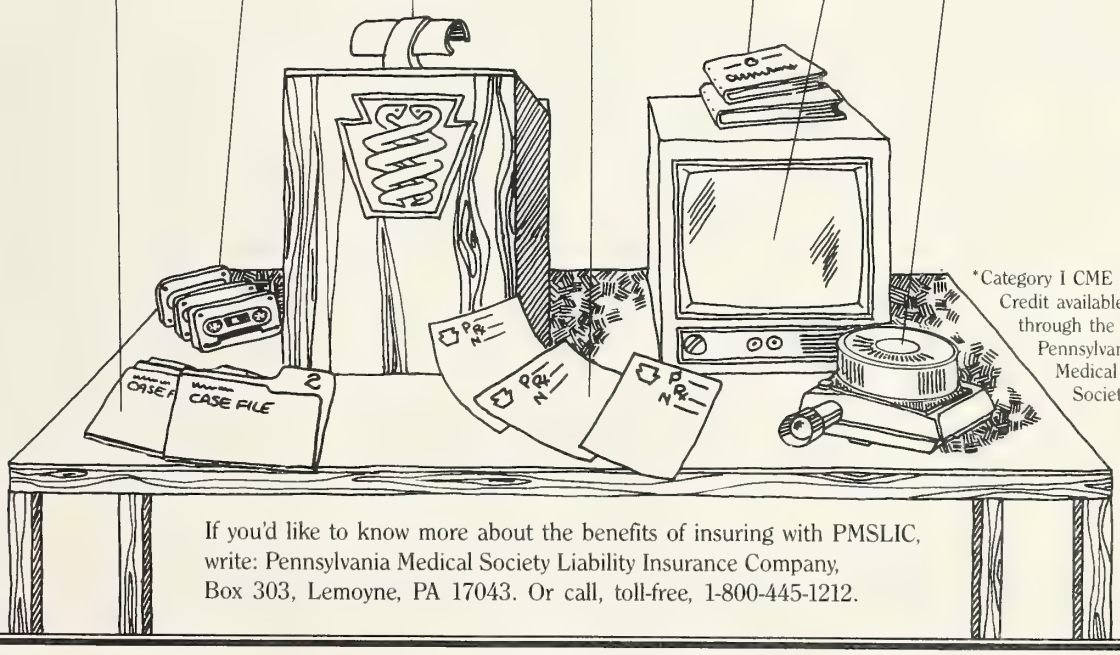

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National Eye Care Project begins in state

"Many people accept blindness as a fact of aging," said Thomas A. Farrell, MD, director of Wills Eye Hospital's General Ophthalmology Clinic. "Their physicians may have retired or the family has moved away—so, they don't get care."

But now, through the largest public service program ever promoted by the American Academy of Ophthalmology (AAO), that no longer has to be true. The National Eye Care Project (NECP), of which Dr. Farrell is the Pennsylvania state chairman, is a nationwide effort to obtain ophthalmic care for the elderly, particularly the disadvantaged.

"The project has a two-fold purpose," said Dr. Farrell. "One is to offer free care to those who cannot afford it, and the second is to bring back into the health care system those who have lost contact with it."

Through the media and contacts with senior citizens' groups, the nation's elderly will be made aware of the NECP. Anyone over 65 who does not have an ophthalmologist and believes that he has an eye problem is eligible. A toll-free number will be set up to accept phone calls. Using a computer, the operator will match the caller with a nearby volunteer ophthalmologist, who has agreed to accept whatever payment Medicare allows. If the patient has no insurance the ophthalmologist will waive his fee. After the name and address of the potential patient is forwarded to the doctor, it is up to the patient to make the appointment.

The $3 million national project budget is being raised through private and foundation grants as well as through direct solicitation of AAO members. As state chairman, one of Dr. Farrell's first jobs is raising funds; he said he is encouraged by the response. "Things are going well. We had five percent of our state goal before we even started the drive." When the needed funding is obtained, Dr. Farrell will enlist volunteer ophthalmologists to see patients. He expects the program to be operating by late 1985 or early 1986.

In three pilot projects in West Virginia, Washington, and Michigan, more than 1,180 patients were seen. Of that number, 60 percent had cataracts; 18 percent, retinal deterioration; and more than six percent had glaucoma. Ten percent of the patients required surgery.

With 1.5 million people over the age of 65 in Pennsylvania, approximately 2,500 referrals are expected. That could mean 1,500 potential cases of cataracts; 460 of retinal deterioration; and 150 cases of glaucoma.

"The prospect of correcting or arresting these potentially blinding conditions is exciting," Dr. Farrell said. "The cost savings and especially the prevention of emotional anguish makes this worthwhile."

Community owns Connellsville facility

Connellsville State General Hospital in Fayette County went from state to community ownership through legislation signed July 15.

"Pennsylvania is the only state in the nation still operating acute care hospitals," Governor Dick Thornburgh said. During the past two years, the Connellsville facility had accrued operating losses totaling more than $3 million, he said. "The divestiture of Connellsville State General Hospital will benefit both state taxpayers, who no longer will have to pay for the facility, and local residents, who stand to receive better care and more responsive management as a result of community ownership."

House Bill 336 conveys 10 tracts of land, with the buildings, to "Connellsville Hospital," a nonprofit, non-stock corporation, which will affiliate with the Forbes Health System of Allegheny County. Forbes will manage the facility.

The transfer also provides approximately $4.6 million in state money during the next fiscal year to help with the cost of renovating and upgrading the facility to meet Life Safety Code and accreditation standards.

The state general hospital system, made up of facilities in Ashland and Coaldale (Schuylkill County), Hazleton and Nanticoke (Luzerne County), Philipsburg (Centre County), Scranton (Lackawanna County) and Shamokin (Northumberland County), was created in 1879 to provide health care to residents in the state's coal regions. Since the early 1920s, the state has attempted to divest ownership and the transfer of Connellsville State General Hospital is the third to take place. Locust Mountain State General Hospital in Shenandoah (Schuylkill County) was transferred to community control in 1981 and Blossburg State General Hospital was transferred in 1972.

The seven other general hospitals are in various stages of being transferred from state to community control.

Ashland Health Tech, Inc., a health facilities management firm located in Philadelphia, has just completed a study of the options for the Ashland State General Hospital. The Community Board is expected to present a proposal for divestiture to Health Tech prior to the end of 1985. It is currently running a $1 million deficit.

Coaldale Geisinger Medical Management Corp. (GMMC) is working with the Coaldale State General Hospital Board of Trustees on the development of a long range plan for the facility. It is currently running a $1.2 million deficit.

Hazleton A new community-based board of directors was announced in May, which will be incorporated into the negotiations with the Department of Public Welfare for transfer of the hospital to local control. The Hazleton facility ran a surplus of more than $2.5 million during the last fiscal year.

Nanticoke The Department of Public Welfare is working with Mercy Hospital there to develop and implement a divestiture plan. An extension to the contract with Mercy for management of the hospital is being prepared. It is currently running a $488,803 deficit.

Philipsburg Legislation and the necessary agreements are being developed to carry out its divestiture plan, which includes turning management and operations over to GMMC. It is currently running a $1.2 million deficit.

Scranton Three hospitals in Scranton continue to develop a proposal for transfer of the hospital to the community. It is currently running a $6.7 million deficit.

Shamokin The long range/strategic plan has been completed by GMMC and presented to the board of trustees of the facility in May. It is currently running a $1.3 million deficit.

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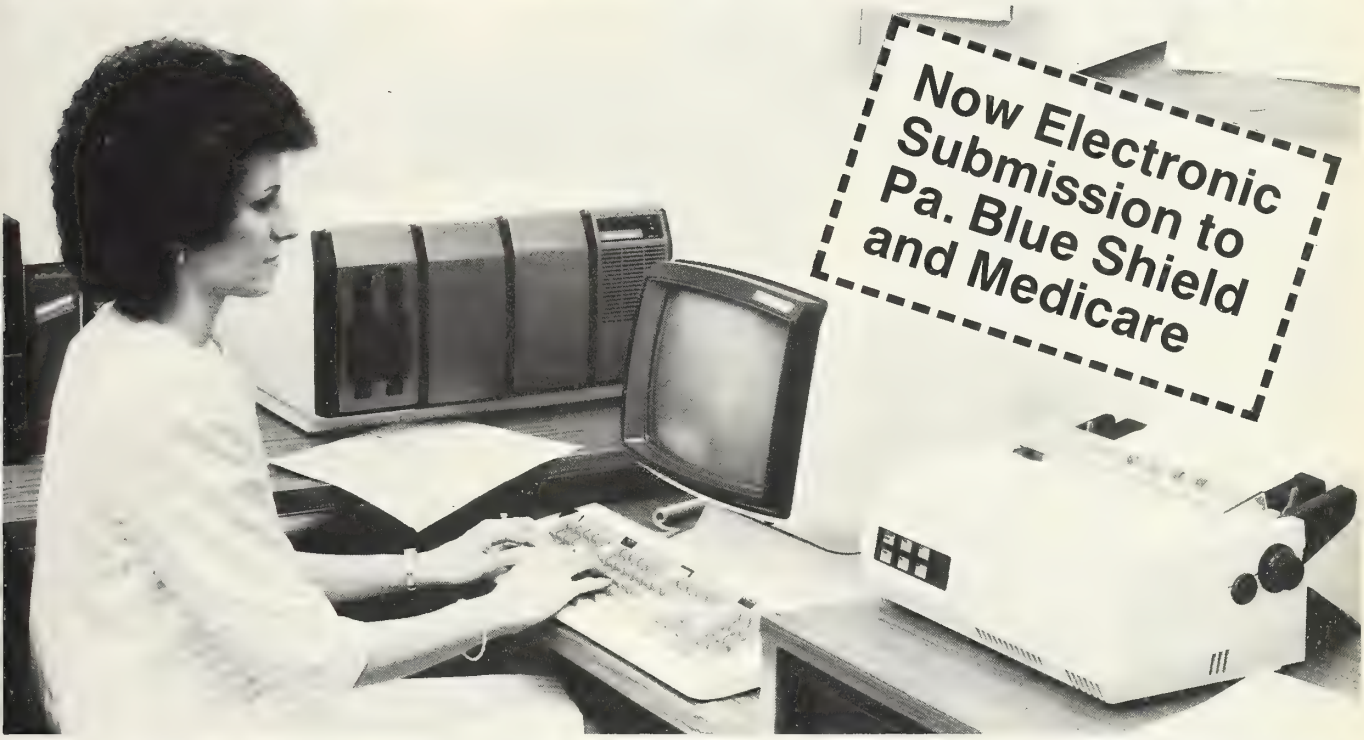

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PAOO installs new leaders, gives awards

Donald P. Vrabec, MD, Danville otolaryngologist, was installed as president of the Pennsylvania Academy of Ophthalmology and Otolaryngology (PAOO) at its 41st annual convention and scientific meeting held recently. Dr. Vrabec, who was previously president of the academy's otolaryngology council, will serve a one year term. He succeeds James L. Curtis, MD, an ophthalmologist from Danville.

Webb S. Hersperger, MD, Carlisle otolaryngologist, was elected president of the otolaryngology council, replacing Dr. Vrabec.

Edward A. Jaeger, MD, Media ophthalmologist, assumed the office of president elect of the academy. Dr. Jaeger will continue to serve as president of the ophthalmology council.

Dr. Vrabec is director of otolaryngology at Geisinger Medical Center, Danville. Dr. Jaeger is professor of ophthalmology and associate chairman of the department of ophthalmology at Jefferson Medical College of Thomas Jefferson University. Dr. Hersperger is clinical assistant professor of otolaryngology at Milton S. Hershey Medical Center.

Also at the academy's annual meeting, awards were presented to two physicians, two speech educators, and a sight official.

The Distinguished Service Award in ophthalmology was presented to Joseph F. Novak, MD, Pittsburgh. Dr. Novak is clinical professor of ophthalmology at the University of Pittsburgh School of Medicine and a member of the medical staff and board of Eye and Ear Hospital, Pittsburgh. For 35 years he has contributed to industrial and occupational ophthalmology, and he developed a mandatory eye protection program for U. S. Steel workers.

The Distinguished Service Award in otolaryngology was given to Eugene Braiden Rex, MD, Philadelphia. Dr. Rex is associate professor of otolaryngology at Jefferson Medical College and serves on the staffs of Lankenau and Bryn Mawr Hospitals.

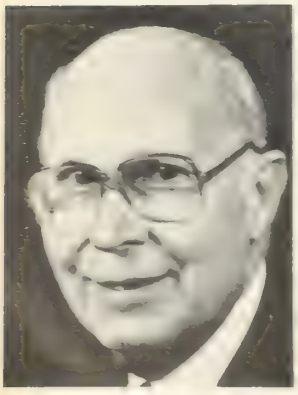
Community Service Citations were presented to William N. Craig, PhD, Pittsburgh, and his wife, Helen B. Craig, PhD. Dr. William Craig is superintendent of The Western School for the Deaf. Dr. Helen Craig is research director at the same school.

Phyllis Kindler, coordinator of volunteer and screening services for the Pittsburgh Blind Association also was honored with a Community Service Citation.

DR. VRABEC

DR. REX

DR. HERSPERGER



DR. NOVAK

DR. HELEN CRAIG

DR. WILLIAM CRAIG

Dr. Masland holds office

David S. Masland, MD, Chairman of the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) Board of Directors, was elected vice president of the Physician Insurers Association of America (PIAA) at its recent Annual Meeting. Dr. Masland succeeds Donald J. Fager, Esq., who was elected president of the organization at that same meeting.

Formed in 1977, the PIAA is a national association of 36 doctor-owned, medical society-sponsored professional liability insurance companies, whose members insure approximately half of all the private practicing doctors in the country.

Dr. Masland served on various PIAA committees over the past three years and was elected to the Board of Directors in 1982.

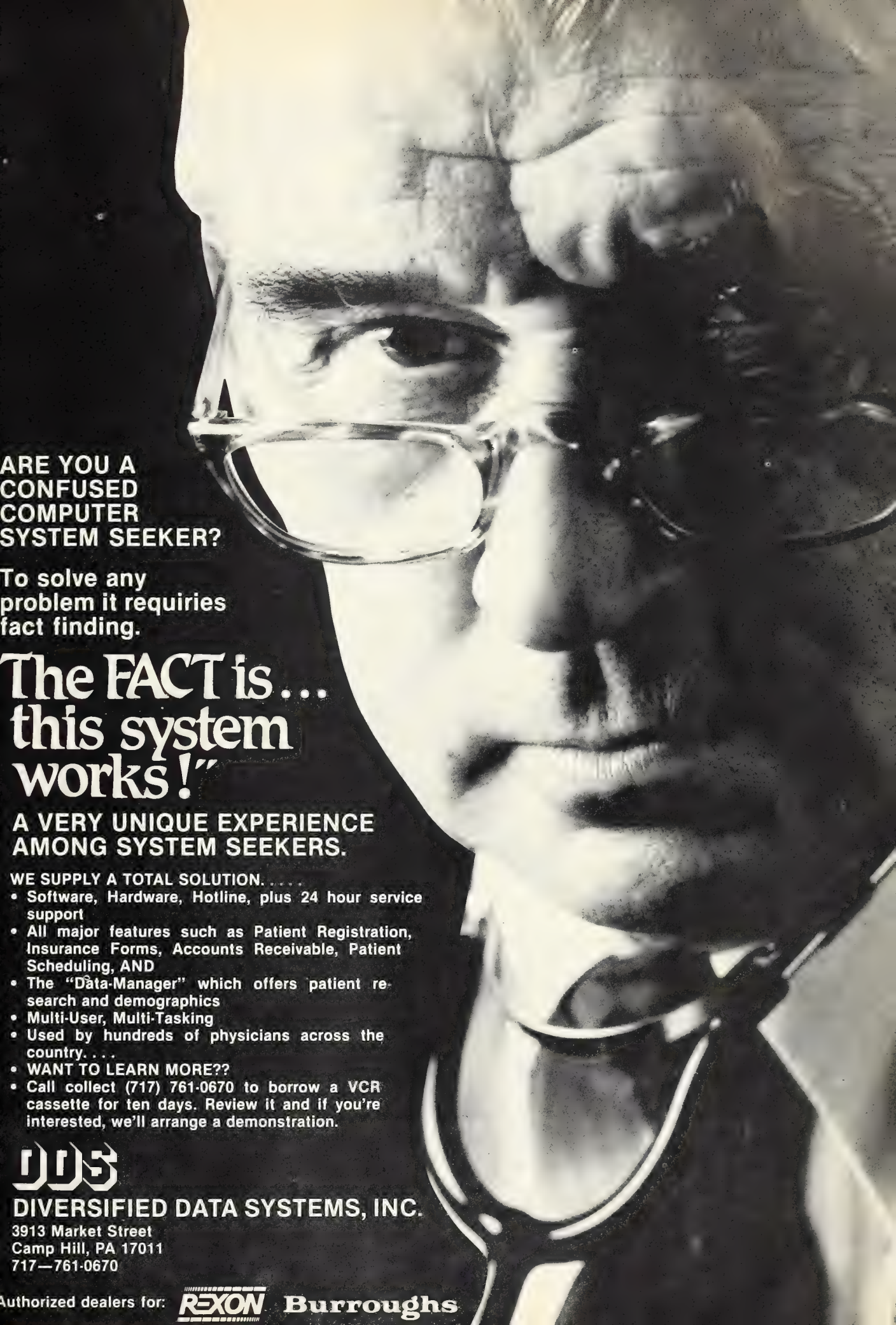
He also has served as a member of the Pennsylvania Medical Society Board of Trustees for 10 years and as the chairman in 1971. He served as president of PMS in 1975-1976.

Seminar on impairment

Douglas Talbot, MD, will discuss the recovery of impaired physicians at a seminar sponsored by the Lehigh Valley Hospital Center, September 14. The program will be held at the hospital center in Allentown from 9-11:30 a.m.

Dr. Talbot is the director of the Georgia Impaired Health Professional Program and the Medical Association of Georgia's Impaired Physician Program. He will speak on the incidence of alcoholism and chemical dependency in physicians, how to identify an impaired health professional, and how to get impaired physicians into treatment programs.

There is no registration fee for the seminar, but pre-registration is required. To register, call 215-776-8981.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in my opinion

Abolish the placebo effect

John L. Coulehan, MD, FACP

It took us a long time to discover the placebo effect, a shorter time to see that it was everywhere, and now we are rapidly translating it into hormones. What began as a response to sugar pills is now becoming a question of endorphins.

Physicians cannot avoid the fact that placebo effects contribute to almost all of therapeutic success. It is easier for us to accept that the history of medicine rides on placebo's shoulders, than it is to acknowledge that we continue to ride there today. No matter where we look—in a clinical trial, in the family doctor's office, in coronary bypass surgery, in a chiropractic adjustment—regardless of what specific effect of treatment we find, there also we find placebo.

But, strangely, we do not talk about it very much. We rarely sit in the doctor's lounge and discuss placebo doses for peptic ulcer. We certainly do not devote much effort to teaching it in medical school. All in all, the placebo effect is an embarrassing secret. We cannot help but suspect that it mocks (ever so lightly) our best scientific efforts.

I propose a solution to the placebo problem. Let us abolish the word. Purge the language, rewrite the textbooks. Get rid of "placebo," "placebo effect" and all their kin. We would need new words, of course, probably several of them, to describe various aspects of healing that we now lump together in the you-know-what effect. But the new words could be selected after careful study. Their meanings would be explicit, and not laden with stacks of emotional baggage. We may even set the stage for an exciting new science of healing.

Let us look more carefully at the placebo effect. The pioneering studies of Howard Beecher and Louis Lasagna during the 1940s and 50s showed that, in any given setting, 30 to 35 percent of patients would have a favorable response to placebo. Their symptoms would lessen. Often physiological parameters, such as blood pressure or joint inflammation, would improve. At first investigators believed "placebo responders" could be characterized, but then it became clear different people responded to placebo at different times—it was not always the same 35 percent. It did seem that the type of placebo treatment made some difference. Stronger "doses," such as surgical procedures, were more potent than pills. Active placebos, drugs that caused some noticeable physiological change (e.g. dry mouth, drowsiness), were more likely to benefit patients than completely inert tablets.

The most interesting research, however, dealt with patient beliefs and expectations. The 35 percent responder rate was a statistical average that concealed more than it revealed. People with medium-range expectations of benefit from their treatment had more beneficial placebo response than those with very high or low expectations. Patients who felt more in control of the situation did better than patients who felt relatively helpless. The placebo phenomenon, we began to understand, was not related specifically to an overt treatment (i.e. a placebo), but rather was a process that occurred in any "therapeutic context." It was the patient's interpretation of what was going on—in other words, the personal meaning of the situation—that determined how much or how little "placebo" happened. These insights led to Howard Brody's "meaning model" which, I believe, is at the leading edge of placebo understanding today.

If we are learning to understand the phenomenon better in any case, why rock the boat? Why abandon "placebo" for new words? I contend that, if we do not try a new language, it will be difficult to translate placebo research and philosophy into useable clinical information.

The first reason for this is our negative emotional reaction to placebo response. Recent hospital surveys indicate that physicians and nurses still tend to think placebo relief of pain somehow means the pain is not "real." Some even use placebo administration as a test to distinguish between somatic and psychogenic pain. This is doubly absurd: first, because all experience of pain is real insofar as it causes suffering, regardless of its origin; and second, because studies demonstrate that patients with somatic pain respond more positively to placebo than persons with psychogenic pain. The cancer patient will get better relief than the neurotic patient who somaticizes. It is perhaps counterintuitive but, within limits, the sicker person does better on placebo than the less sick. Now if we were using other terms—let us say, for example, the neuroendocrine component of healing—these concepts would be easier for us to deal with and use.

A new vocabulary would make it easier to study the harm, as well as the benefit, produced by placebo effects. We are all aware of iatrogenic suffering caused by the side effects of medications. Inert placebos also have side effects as evidenced by the wide array of symptoms reported by control group patients in clinical trials.

We all have seen patients who do poorly on a medication or course of treatment, and report inexplicable symptoms that they attribute to the drug. Our first inclination is to reassure the patient that the new problem could not be, or is extremely unlikely to be, a side effect or allergic reaction. But if we accept that meaning, in this case a negative interpretation, may lead to physiological change, then it may well be that the negative placebo effect or "nocebo" effect did cause the symptoms. Moreover, the patient can come away from his visit to the doctor with an increase in suffering simply because the doctor confused him, did not answer his questions, or in some other way increased his anxiety level. If we take credit for the good art of medicine, we cannot avoid accepting blame for the results of the art that's poorly done.

The final reason we should abandon "placebo" is that it gives us no indication of power or quantity. The word connotes *one* response, rather than an extremely wide range of possibilities. We

The author is associate professor of community medicine at University of Pittsburgh School of Medicine.

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think of it as hazy and mild, rather than clear and dramatic. Yet, as Jerome Frank argues in his classic *Persuasion and Healing*, the placebo effect may be an extremely strong force for either healing or harm. It is quite possible that miraculous healings or spontaneous cures of cancer may represent one limit of the human potential in this respect, while cases of "Voodoo" death represent the opposite limit.

We can modulate to some extent the "dose" of placebo in our own practices through conscious attention to empathic responding, clear communication, and attention to the patient's own beliefs and values. However, we are totally in the dark about how to predictably cause very strong influences such as those which sometimes occur "spontaneously." Yet, abandoning "placebo" talk may allow us to study these influences more systematically and perhaps gain better control over them.

What can we use instead of "placebo"? The phrase already mentioned, "the neuroendocrine component of healing," has a certain descriptive validity, but would sound better as a specialized term for laboratory use rather than a clinical concept. I believe it is useful to think of anything doctors do to help patients as having three dimensions: a focal dimension, which is the intended physiological change caused by the medication, surgery or other treatment; a behavioral dimension, which is how it influences the patient to *do* something, such as take the medication or follow dietary advice; and, finally, a symbolic dimension, which is how it influences the patient to experience the illness differently, by decreasing anxiety or changing its personal meaning. Any interaction we have with the patient has some component of each of these three dimensions. Talking about the "symbolic" aspect of healing rather than placebo might be a step in the right direction, but it is certainly not the answer. Yet, if practicing physicians work harder on the symbolic dimension, and if laboratory researchers work harder on the neuroendocrine axis, perhaps we will be on the road to an exciting new science of healing. □

Advertising, cigarettes, and women

J. Mostyn Davis, MD

The tobacco companies say the intent of the intense $1.5 billion yearly cigarette advertising budget is to get adult smokers to switch from Brand X to Brand Y. Someone should tell the tobacco manufacturers that their ads have a far different effect than the one they claim. The image they leave is that smoking will make a woman (at least in her fantasy life) slim, young, healthy, and sexy.

Long have I harped on the theme of the double damage caused by cigarettes in women—that of the physical injury of smoking itself as well as the secondary damage to the fetus during pregnancy.

Recently ten prominent women's magazines that accept cigarette ads were surveyed as to their stand on the health effects of cigarette smoking. During the time period 1967 to 1979 (12 years), a grand total of eight articles in these magazines discussed quitting or the dangers of smoking. This amounts to less than one article per magazine for more than a decade! Four of the ten had *no* antismoking articles in the entire 12-year period.[1] Since smoking-related cancer is now, or will be this year, the most common cancer in women, these findings suggest that advertising revenue dollars are more important to the publishers than the health of the subscribers of their magazines.

Television does not have an outstanding track record either. Even after the scientific evidence against smoking had been established, it became necessary to pass a federal mandate to curtail advertising on television. We still have been unable to get smoking out of the programming, especially detective and adventure series. When I hear of the Codes of Good Broadcasting, I know they do not refer to the *health aspects* of good broadcasting.

Dr. Arthur Holleb, senior vice president for medical affairs of the American Cancer Society, reports that of more than 50 women's organizations contacted about the smoking issue, "some were feminist, some not, some were national, and some local, but most failed to reply."[2]

Among prominent news media that have failed to put the welfare of their customers ahead of profits are *Time, Newsweek,* and *The New York Times.* The November 7, 1983, edition of *Newsweek* carried a 16-page supplement provided by the American Medical Association entitled, "Personal Health Care." All but four sentences about smoking were edited out of the supplement. That same issue carried 12 pages of cigarette advertising, said to be worth close to $1 million in revenue. *Time* magazine did the same thing to a special section provided by the American Academy of Family Physicians in the October 8, 1984, issue. The academy claims *Time* removed discussion of the health hazards of smoking without the knowledge of the academy. *Time,* in that issue, carried eight pages of cigarette advertising.[3]

Robert Smith, the *Times* advertising acceptability manager, has said that the *Times* was not likely to change its policy on cigarettes in the near future. He pointed out that cigarettes are not outlawed products and he feels that the readers are aware of the dangers and can make up their own minds. The *Times* makes about $12 million a year in cigarette advertising.[4]

It would appear that women are in for a rather disagreeable learning process. Basically refusing suggestions from the medical establishment, they are getting no direction from their own women's groups, and certainly no help from the media. We, as physicians, need to offer help and encouragement to every one of our individual women patients who smoke to get them to stop smoking. We also need to keep pressure on the tobacco industry and the advertising media to that same end. I for one will be thrilled to see that rapidly rising lung cancer line on the graph level off and begin to descend. Join me in this hope and in the work for the elimination of the group of diseases related to cigarette smoking. □

The author is in the department of family medicine at Geisinger Medical Center, and is the PMS trustee representing the Fourth District.

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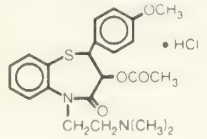

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2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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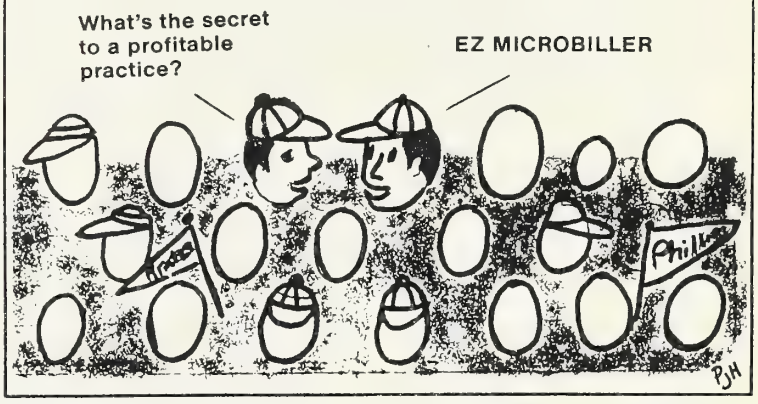

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practice management

Staff plays role in marketing practice

Leif C. Beck, LLB, CPBC
Geoffrey T. Anders, JD, CPBC
Dorothy R. Sweeney

So much is said these days about marketing, the most recent buzzword in medical practice management. Although the subject deserves most of the attention it receives, one aspect often is overlooked. This point is that marketing begins in-house—within the practice itself. All the fancy business planning, marketing strategies, and expensive promotional campaigns will accomplish very little unless the practice's key players—both physicians and lay staff—fully support it.

For example, a large group practice was ready to sign an advertising agency contract for $100,000 to promote its expansion into certain new activities. Unfortunately, however, its physicians had not reached an agreement about those activities, and the telephone and reception employes actually were discouraging the types of patients the advertising campaign wished to attract. The advertising would have been wasted unless the group's own players first became unified.

On a smaller scale, one physician in a three-member group was not convinced that the practice should proceed in the direction the doctors generally planned. A few of the key staff members, sensing the owners' indecision, were undermining the chosen direction in their patient encounters. Strategic decisions could not be made until leadership and decision-making formats gave the physician members a unified front.

The authors are principal consultants of The Health Care Group, Bala Cynwyd.

Involving the key players

The point of these examples should be obvious, although these problems sometimes are difficult to solve. An organization must be unified in its basic goals and strategies to accomplish them. "Marketing begins internally."

When a practice starts to develop its basic business plan, it should involve all of its key players. A group should be certain that each physician member contributes to the process and that the proposed plan has been thoroughly discussed and openly approved. If a member is so opposed to the plan that he or she will not support it, perhaps withdrawal from the practice would be best. We feel the group (the practice) is more important than any one individual physician.

Small practices should share the planning process with the office manager or senior assistant. Without his approval and backing, any proposed changes could easily become buried before the physician is aware of it.

Better results

With that start, the plan will have a better chance of being carried out. Changes in practice emphasis should be self-fulfilling when all the participants act with the selected goals in mind. Promotional efforts to emphasize a new satellite, availability to another group of patients, or a different disease or procedure orientation would be far more likely to succeed.

Internal marketing requires leadership at the physician level; we often say success or failure comes from the top. Among a group of doctors, the leadership must find the consensus and then encourage physicians to stay on-line. For a small or solo practice, it may be necessary to train the staff to understand the larger goals for the practice. Whatever the size and style, your marketing effort should start inside the practice. □

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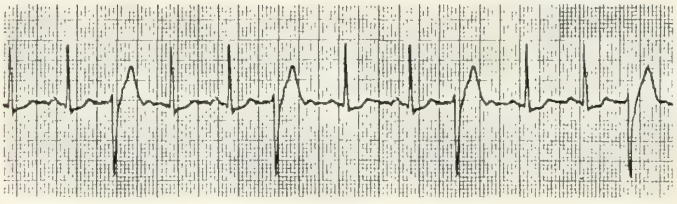

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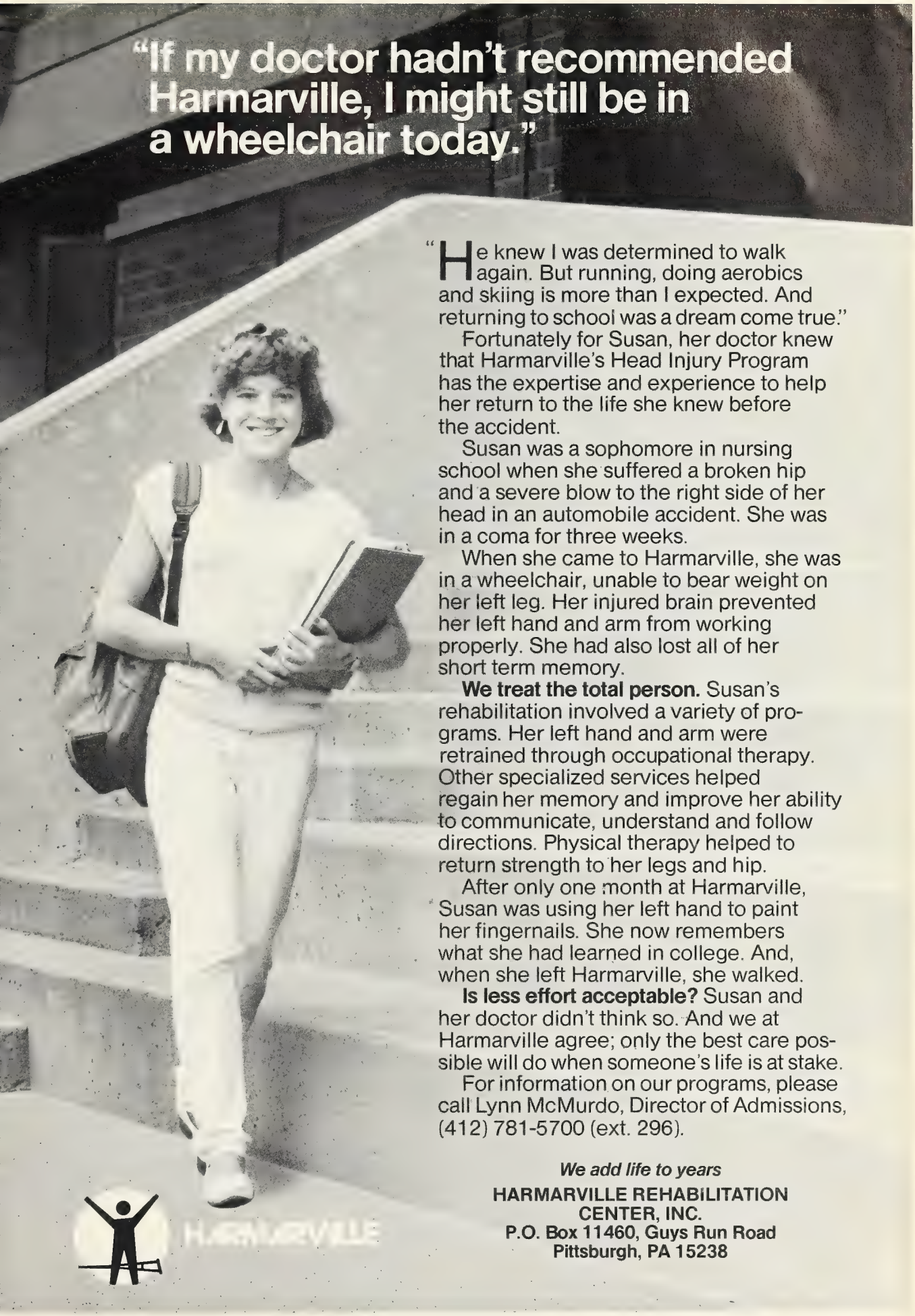

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Drugs, computers, and physicians

Charles Heisterkamp III, MD, FACS

Avoiding adverse drug interactions when treating a patient is an increasing problem for physicians. The factors contributing to the problem are increasing in complexity and diversity. However, a solution is offered.

More drugs are available to treat patients. This diversity is a boon to the better management of our patients' problems. But it also creates a new problem. The physician must remember an increasing array of potential interactions between drugs. In addition to this, many patients are cared for by several physicians, each doctor a specialist in a limited field. The situation occurs both within the hospital and without.

A related problem is that of drug-test interactions. It has become difficult for a physician to remember all the areas of drug-test interaction. Receiving an abnormal test result can be expensive, requiring additional tests and procedures, and can be physically and emotionally damaging to the patient, particularly if an invasive test is ordered. The economic incentive can be critical if the payment for all the patient's services will be a fixed, predetermined amount.

While clinically not recognized to the same degree as drug-drug interactions, knowledge of drug-food interactions is becoming more important.

In a stable situation where the commonly used drugs were not frequently changing, one could "learn" the answers or use a standard text or a set of tables. However, this is not the case, and these solutions are not practical.

But an economical answer is readily available. With current microcomputer equipment and telephone communications, a physician could offer his or her patient an "instant" analysis of potential drug problems by accessing a central data bank that would contain up-to-the-minute data on drug-drug and drug-test interactions.

Dr. Heisterkamp is a member of the Society's Council on Economics and chairman of the subcommittee on computers.

There is an added important benefit to providing such a service. If the central data bank had access to the basic patient demographic data (sex, age, zip code) and basic medical data (diagnosis and date of diagnosis, major procedures and date, current or proposed drug therapy, and drug history) one would know more about the health of the population than is now known. Appropriate ongoing analysis of data could provide information on topics as diverse as emerging epidemics to the prescribing habits of physicians.

Finally, application of the "prudent man rule" as espoused by Judge Learned Hand suggests a final imperative for any physician to use the system and avoid malpractice.

The prediction and detection of drug-drug interactions, as well as drug-test interactions is an overwhelming problem for the physician. Fortunately, an economical solution and one which also offers significant tangential benefits is available. □

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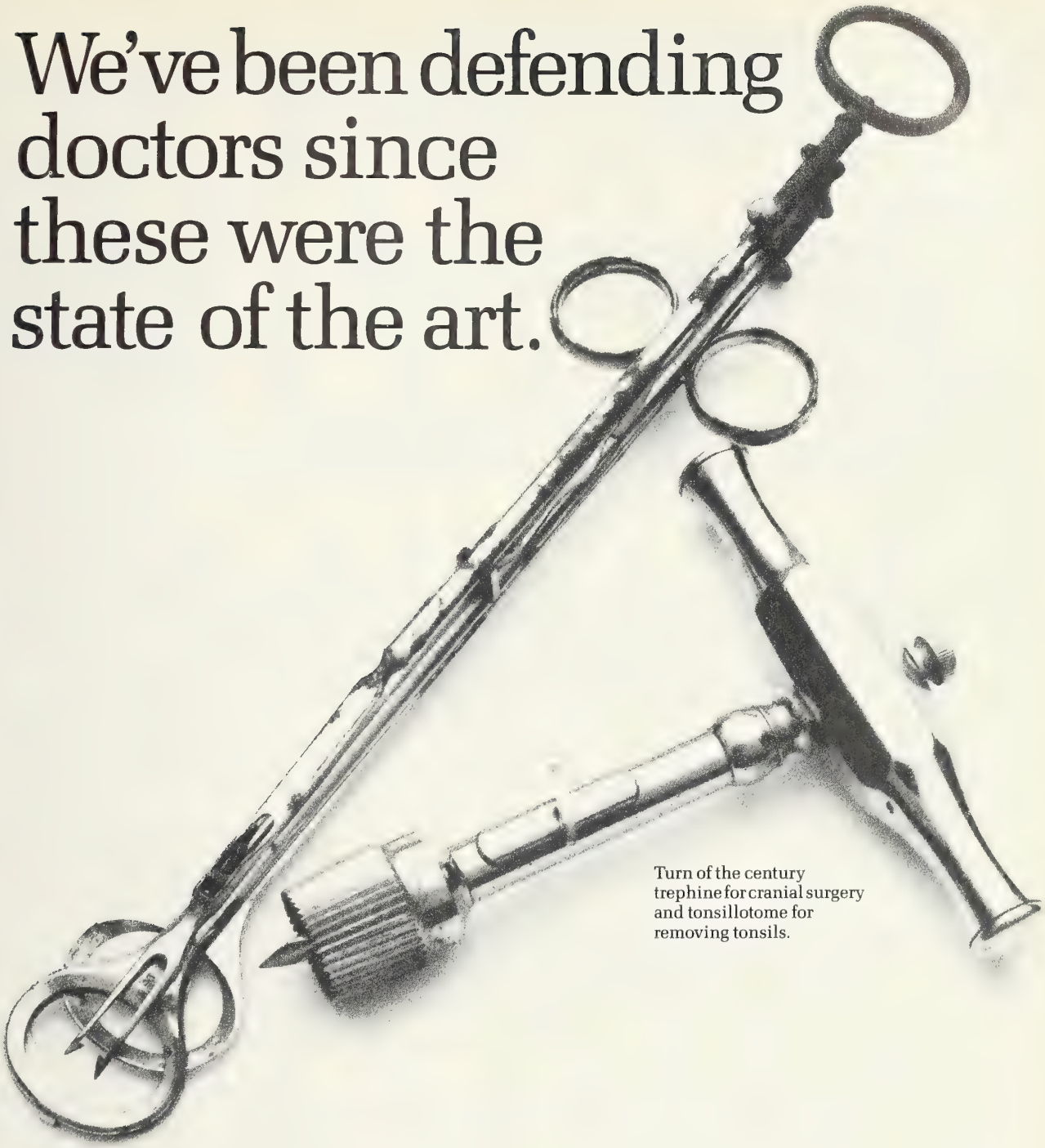

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capital commentary

Eleven bills on health costs due House action

Robert H. Craig Jr.
Jerry L. Rothenberger
Larry L. Light

One June evening as the General Assembly was concluding its work on the budget and preparing to adjourn for the summer, there was a great deal of activity in the rear of the House chamber. In addition to the usual last minute lobbying on the budget itself, two organizations, the Insurance Federation of Pennsylvania and the state Chamber of Commerce, were summoning representatives from the floor to ask them to cosponsor their health care cost containment bills.

After the dust had settled, we noted that a total of 11 bills pertaining to health care cost containment had been introduced during the first six months of the 1985-86 session.

Philadelphia Democrat Mark Cohen introduced the first package of bills in May. Drafted by the Pennsylvania AFL-CIO, the four bill package covers utilization control, second opinion, indigent care, and restrictions on health care facilities.

Here is a brief review of the bills.

House Bill 1161—Cohen—Establishes a utilization control program to include preadmission review, concurrent review, and retrospective review (AFL-CIO package).

House Bill 1162—Cohen—Mandates second opinion for certain surgical procedures and other requirements for health care insurers (AFL-CIO package).

House Bill 1163—Cohen—Amends the Health Care Facilities Act, expanding the definition of a health care facility and adding restrictions (AFL-CIO package).

House Bill 1164—Cohen—Establishes a health care cost reform commission, an indigent care fund, an indigent care pool, and a state health plan (AFL-CIO package).

The package of bills drafted by the Pennsylvania Chamber of Commerce was introduced just before the recess at the end of June. Three of the bills were introduced by Representative David Wright (D-Clarion). The fourth proposal was introduced by Representative George Saurman (R-Montgomery).

The package contains these bills.

House Bill 1582—Wright—Establishes Pennsylvania Health Data Council (Chamber of Commerce package).

House Bill 1583—Wright—Provides for health care facility utilization review, including second surgical opinion, preadmission, review, etc. (Chamber of Commerce package).

House Bill 1584—Wright—Provides for independent review of mandated health benefits (Chamber of Commerce package).

House Bill 1602—Saurman—Provides for limits on annual capital expenditures for new institutional health services (Chamber of Commerce package).

The Insurance Federation's comprehensive bill was sponsored by Beaver Democrat Charles Laughlin. It is the only health cost legislation not referred to the House Health and Welfare Committee. This bill was referred to the committee he chairs, the House Consumer Affairs Committee, and is summarized here.

House Bill 1554—Laughlin—Establishes the Pennsylvania Health Services Council; provides for data collection, uncompensated care pools, and utilization review; and prohibits hospital rate and charge negotiations (Insurance Federation).

A single bill sponsored by Representative Carmel Sirianni (R-Susquehanna) was introduced in April.

House Bill 885—Sirianni—Establishes a health data collection panel.

Representative Saurman also introduced his own bill, requiring second opinions, in May.

House Bill 1191—Saurman—Requires health insurers to offer a program for second medical opinions for specified surgical procedures.

Health care cost containment legislation has been a hot political topic since the beginning of this session of the General Assembly. The initial speculation concerned which committee would gain control over the bills. For the most part, the winner was the House Health and Welfare Committee, chaired by Representative James D. Barber (D-Philadelphia). Representative Barber, a nine-term House member, has scheduled public hearings for August and September. To date, no bills have been introduced in the Senate relating directly to health care cost containment, so no activity is scheduled by committees of that chamber. It is uncertain what activity Representative Laughlin may have planned for his bill in the Consumer Affairs Committee.

The Society's policies on cost containment, including those elements of the various legislative packages that were already identifiable, have largely been developed by the Task Force on Public Policy Aspects of Competition and approved by the Board of Trustees. The task force is chaired by Robert N. Moyers, MD, Eighth District trustee from Meadville. They have been reviewing proposals on cost containment for nearly two years. During that period the Society has been represented by R. Robert Tyson, MD, of Philadelphia, and staff at meetings of the Chamber of Commerce and the Business Council of Pennsylvania.

There is every reason to believe that the General Assembly will remain committed to the passage of cost containment legislation sometime during the remaining 18 months of this legislative session. Although the bills now under study are wide in scope, only certain main issues must be dealt with now. In that category are issues such as mandated benefits, utilization review and second opinions, data collection, uncompensated or indigent care, caps on capital expenditures, and rate control.

Any legislation faces the likely fate of extensive amendments in both the House and the Senate. During that process these issues will be at the center of the discussions on cost containment.□

The authors are the staff of the Council on Legislation. Mr. Craig is director, Mr. Rothenberger is assistant director, and Mr. Light is legislative liaison.

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The last Grand Rounds of Richard Selzer

Charles I. Schuster

Grand Rounds. Richard Selzer has written about the event in *Letters to a Young Doctor.* It is a ritual evolved from centuries of Hippocratic tradition. Once a week the medical faculty gathers to hear a case presented. Patient histories are dissected, treatments debated; reputations gained or lost. More than mere presentation, Grand Rounds is a performance. "Choose your patient carefully," Selzer had advised in *Letters*, "and rehearse as if you were Pavarotti singing *Tosca* at the Met."

Never has this been truer than Saturday morning, December 15, 1984. At 9:00, Richard Selzer—surgeon and writer, assistant clinical professor at Yale University School of Medicine, author of *Rituals of Surgery, Mortal Lessons, Confessions of a Knife,* and *Letters to a Young Doctor*, winner of the National Magazine Award and the Medical Writer's Association Award, recipient of several honorary doctorates, and one of the original participants in the medical humanities forum at Penn State that has led to a humanistic shift in medical schools all over the country—Richard Selzer on this day will present the final Grand Rounds of his surgical career. He has announced his retirement from medicine, effective January 1st, 1985. This is his valedictory, his last public outcry as doctor to doctors. It is the end of one life and, he hopes, the beginning of another.

Because Richard Selzer is no ordinary doctor, this last Grand Rounds takes on special meaning. Selzer is the surgeon who celebrates the art embedded within science, the doctor who washes first blood and then ink from his hands. He is the surgeons' confessor, and even worse the betrayer of operating room confidences, a kind of George Plimpton of medicine—except that with Selzer, art is truth and both matter at least as much as fact.

Richard Selzer—the surgeon and writer

His four collections of stories and essays are required reading in many medical schools and are discussed and analyzed in literature and composition programs in high schools and colleges across the country. His books have been translated into French, German, Portuguese, and Japanese. Hardly a day goes by without a request appearing in the mail: to speak at a medical school, to submit an article to *Self* or *Art and Antiques* or *Harper's*, to give permission for a movie to be made based on one story or another, to grant an interview, to be the object of study for a dissertation. It is hard to maintain two full-time careers under such circumstances. Richard Selzer has decided to retire from one of them.

"I am a writer"

Saturday morning, December 15th, 7:30 a.m. Richard Selzer has already been up for hours, up most of the night. "This is one of the most difficult events of my life," he tells me as we sit in the front seat of his decrepit, twelve-year-old Datsun waiting for the car engine to warm. "I am only able to do this by thinking of the very few things that I would rather not be doing." He does not enumerate. We drive the short distance between home and Yale-New Haven Hospital.

For the past six months he has alternated between elation and despair. "On Wednesday I will be delighted, on Thursday in dread. Surgery has been a central part of my life for thirty-one and one-half years. I don't think I ever would have become a writer had I not been a surgeon. But I must leave it now. It is time. I must." It is both acknowledgement and argument, directed to himself. Selzer is only fifty-six, young for a surgeon to retire. What makes it all the harder is his love for the daily round of medicine, a love that has fed his work. In April of 1982, Selzer told me that if he left surgery he was afraid that he would "lose the writing altogether." Now he is more concerned that he will die as a writer if he does not leave his surgical practice. His writing has grown in scope since he first began publishing in the early 1970s. He has subjects he wants to write about beyond medicine. He does not know if the writer is essentially the surgeon, but he does know that he can no longer be the two of them simultaneously. If writing is the demon within him, then retirement is a reverse exorcism in which the conventional, 40-hour-a-week soul is washed away leaving only the chaotic, creative spirit.

"I am a writer," Richard Selzer states simply as we drive south toward the

hospital. True, but not in 1953 when he first arrived in New Haven as an intern at what was then New Haven Hospital. Born and raised in Troy, New York, son of a general practitioner, Selzer attended hometown Union College and went on directly to Albany Medical College. Without pause, he arrived in New Haven committed to a career in medicine.

Like the other interns, he lived in the hospital, receiving $25 a month plus room, board, and laundry privileges for the opportunity to work 36 hours out of every 48, holidays included. The following year, stipends were raised to $50 a month. Perhaps feeling opulent and certainly more inclined toward marriage and family, he met Janet White. After a whirlwind courtship of only three weeks, he discovered that he was drafted, flew to Texas for basic training, and then returned to New Haven to marry Janet. Five days later, he was flown to Korea where he set up a medical camp in the remote hills south of the DMZ. Exiled from home, wife, medical school, and most of the U.S. Army, he organized a provincial practice, treating the ills of "the indigenous," as the Korean people were called then, until he contracted his own diseases: malaria and amoebic dysentery. It took a year to recover, a year in Japan with Janet joining him by freighter and the two of them learning how to live together.

Returning in February of 1957, Selzer resumed his first year of residency two years behind his original classmates. Enduring their academic superiority proved difficult; they seldom let him forget that he who was once their colleague was now but a first-year intern. Such is the hierarchy of medical school against which Selzer often rails in his work. But he has never regretted his Korean experience. "I had never before been further away from home than 150 miles," Selzer told me. "Here, suddenly, I was in another world. When I arrived by jeep in my primitive camp, I knew that I was there for good, that I would never be seen again by western eyes. I had to make the best of it—and I did. It was a great adventure. It proved to me that I could accomplish great things in spite of overwhelming odds. I loved it. I loved every minute of it. I did not want ever to leave, even though I was almost dead at the end." But leave he did, and in January of 1961, with Korea five years behind him, he established a private practice as a general surgeon in the city of New Haven.

Recalling those early years, Selzer says, "It was as if I were sleep walking. I was not unhappy; I did not yearn for some other existence. I was fully contented with family and my surgical practice." With some pride he recalls that he "worked pretty darn well for ten years, fifteen years." Within a year of beginning practice, he was joined by fellow surgeon and lifelong friend, Bernard Siegel, known now internationally for his holistic approach to surgical healing.

Ultimately Selzer and Siegel expanded and became Surgical Associates. Successful, comfortable, married, the father of three children, Selzer seemingly had what life could offer. But there was another Richard Selzer lying dormant within the surgeon. Slowly it awoke and, piece by piece, began dismembering the doctor's orderly life in order to gain the open air. There was no stopping this urge, no denying the need for transformation. No matter how many years the locust lives under ground, it must finally clamber into the sunlight and stretch its wings. On this Saturday, December 15th, the poet-writer is about to declare his independence as he wrenches himself clear from one life to another.

Workshop of decades

When we arrive at 8:15 a.m., Yale-New Haven Hospital is fairly quiet, but already a small crowd is gathering in the corridor outside the entrance to Fitkin Amphitheatre. Inside, medical students and faculty listen to a lecture, but for most of those in attendance the real event is yet to come. Richard Selzer waits nervously in the corridor, greeting, friends, colleagues, staff. Then he absents himself and wanders part-way down an intersecting hallway to study once more his notes.

Soon there is a short intermission. A few people hurry out of the ampitheatre and scatter through the hospital like microbes, while the corridor crowd enters through the pit door and begins to fill the room. In the back, a video camera is being set up to record the event. Reporters from local newspapers sit in the front row. Several other people prime their portable tape recorders. There is quiet talk. Almost all the seats are taken, most of them by men and women who wear the white lab coats that serve as emblems of their profession. We sit and wait for Richard Selzer inside this room which is so much a part of the Yale medical tradition.

Fitkin Amphitheatre is designed in the old style, an impression furthered when one learns that it was constructed as part of the original New Haven Hospital building and dates from 1826. Established by Abram Fitkin and dedicated to his son Raleigh, dead at the age of 10, it is medium sized as amphitheatres go, with approximately 150 seats that curve in a semi-circle around the pit. In the pit is a podium; behind it a large blackboard flanked by television monitors. A shoulder-high barricade rims the pit, defining the territories of audience and participant. It is a room designed for maximum observation and performance. It is arena, auditorium, stage. No longer do surgeons in frock coats, cravat, and top hat demonstrate their art bare-handed to admiring students, but standing in the pit one can feel their bearded presence. Richard Selzer has been here before—many

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Today marks a departure, a precedent even for Richard Selzer. For the first and most likely the last time in the history of surgical Grand Rounds at Yale, a surgeon will talk not about his cases, but about himself.

times—mostly as an observer to hear the kinds of talks that have preceded the one that he is about to deliver. Almost invariably these talks are technical affairs, like the ones currently listed on the notice that hangs from a bulletin board outside Fitkin:

November 10, 1984: "Reflections on Looking into the Colon"

November 17, 1984: "Surgical Reconstruction of Cardiac Valves"

December 8, 1984: "Treatment of Advanced Primary Breast Cancer"

Richard Selzer has been not only an observer but a participant of Surgical Grand Rounds. For the first fifteen years of his career, his subjects were always clinical: presentations on cases such as appendicitis or melanosis coli. Since the mid-1970s when he won the National Magazine Award and published *Mortal Lessons*, his appearances have consisted of readings from his work. Today marks a departure, a precedent even for Richard Selzer. For the first and most likely the last time in the history of surgical Grand Rounds at Yale, a surgeon will talk not about his cases but about himself. Unorthodox as it may be in the world of scientific medicine, he will be personal, confessional, even emotional. He will express both thoughts and feelings. The title as listed on the bulletin board notice is deceptively simple:

Dec. 15, 1984: Richard Selzer, M.D.
"The Surgeon as Writer."

Richard Selzer enters through a door set in the back wall of the pit. After a short introduction by the acting head of the surgery department, Selzer begins with a comic anecdote that looks backward to his first operation at Yale on July 1, 1953. "I arrived at the hospital with a bad case of poison ivy on my forearms and hands," he informs us. "And then I was forced to scrub for 10 minutes with a wire brush made of something worse than boar bristle or walrus fibrosis"

In Fitkin there is loud laughter as Selzer expands upon the misery he endured that day. The audience is his—as he is theirs—and they express their appreciation openly. He will be witty this final round of his career. As he wrote in a letter to his friend, the pathologist Bill Ober (a letter that characteristically will likely never be sent), "Nor can one wave a cheery ta-ta to the workshop of one's decades. But I am determined to walk out of the amphitheatre to the roar of laughter and not the sound of sniffles." Contrary to his resolve, however, there will be some tears before the morning is through.

Between contentment and longing

"Today," he says, "it is with mixed pleasure and pain that I, Richard Selzer, author of *Mortal Lessons, Confessions of a Knife*, and a lot of other flatulence and eructations, announce that after thiry-one and one half years as a surgeon I have decided to retire from the practice of surgery as of January 1st. For the past fifteen years, as you well know, I have stabbed intermittently at an inkwell, and all in all I have felt myself privileged to have been allowed to swim and shoulder halfway across the river of Art. It is to immerse myself fully in that current that I take my leave from your midst, absent myself from all this felicity, don't you know."

He looks coyly at the audience over his horn-rimmed glasses, and they laugh knowingly with him. Felicity is not quite so common as this moment suggests. Yet for now at least there is an adoration present, felt by both speaker and listeners. Selzer speaks slowly, dramatically, even melodramatically. Anxious though he may be, he also is in love with this moment. There is an archness in his voice, an affected and affecting delicacy of manner that makes one think of plumed hats, scented handkerchiefs, the lilting gait of renaissance courtiers. "When I die," Selzer once told me, "I hope to go to heaven and sit at the right hand of Sir Thomas Browne."

Even in his white coat, behind the podium, beneath the glare of camera lights, he seems out of place—a highly cultured man who has just emerged from an Elizabethan time capsule. Bound up in his persona is the irrepressible urge to play to his audience, to pose, as if always aware that a royal presence is offhandedly monitoring his performance. One can hear it in the latinate construction of his sentences, feel it in the droll gaiety of his vocalic delivery. He seems not quite of this world.

"And who can say," Selzer continues, "what will arrive at the doorstep of my mind, what hitherto undiscovered way of saying something about a liver, the eschar of a burn, a toenail, or—wild, wild hope—one of *you*? Believe me when I tell you that to be a surgeon is a fine and noble thing, and, compared to psychiatry or dermatology, it is satisfying to the boisterous spirit. I think myself wonderfully honored to have been brothered and sistered these many years by you."

The deliberate pacing of his talk is punctured by laughter, and by the insistent beeping from portable audio devices carried by the medical staff. Throughout this 50-minute presentation, beepers will interrupt Richard Selzer followed by calls for surgeons to come to bedside and operating room. But few of them move. During this Grand Rounds, only one physician will leave unobtrusively by back door. For an hour at Yale-New Haven, the hospital survives without its surgeons.

After a brief excursion into the history of medicine, Selzer begins to talk about himself as a writer. "For some little time now," he says, "I have felt myself to be a nightingale among a flock of owls and peacocks—a nightingale, possessing neither the wisdom of the owl nor the beauty of the peacock, but only the throat that strains to sing. Believe me again when I tell you that to be an

artist, a writer, why that is for me fresh air, pure water, a meadow full of wildflowers upon which is seated the Boston Symphony orchestra playing Beethoven's Ninth. I have always loved the art of words and the appearances of life. So nothing for it but to become an author."

Couched within this elaborate confession is Selzer's awareness of his status as an alien within the medical community. A few days later, in another context, he said to me, "Of the 300,000 surgeons, I am the only one committed to this art. As a young man, I backed into the wrong room and became enamored of my prison. But you know that you are not one of them, no matter how long you stay in the same room and wear the same white coat. First you sing under your breath, and then louder, and louder, until at last they hear you."

For now, however, Selzer feels part of the community with Fitkin. He continues: "Still, the man who begins the life of a writer at the age of fifty-six toils indeed under the very dart of death. Like another writing doctor, John Keats, I too have fears that I may cease to be before my pen has gleaned my teeming brain. Lately, getting up in the middle of the night to come here for a perforated ulcer or an appendicitis, I have the notion that my body is still intact only because it cannot decide in which direction to collapse." Selzer pauses for the sympathetic laughter. "And I feel more and more the pressure to let ink flow until there is a mile of it behind me. Just to see. For no one knows what he will write until he does it . . . But do not imagine that laboring in prose is a light-hearted pursuit. It too is a matter of life and death. It has to be or it won't be worth the paper it is written on. Nor should you think that these stories and essays and memoirs of mine are insignificant in the grand scheme of things. Trifling though they may sometimes be, they are tenacious trifles and will far outlast the collected colectomies of my life."

It was Horace who declared in one of his odes, "I have built a monument more lasting than bronze." For Selzer, too, art represents the promise of immortality. In a later discussion he said to me, "My surgical work is nothing. My life is really nothing. This," he said, pointing to the manuscript pages spread out on the desk before him, "this will outlive me. As Denise Levertov once asked me, 'To whom are you devoted—your friends or your art?' It must be your art—above everything." In his own serio-comic fashion, he wants his audience in Fitkin to understand that it is no mere whim that propels him into a life of writing.

'For some time now, I have felt myself to be a nightingale among a flock of owls and peacocks—a nightingale possessing neither the wisdom of the owl nor the beauty of the peacock, but only the throat that strains to sing.'

Selzer looks up now at the friends and colleagues before him to ask a rhetorical question: "What will happen to me after January first?" And then in a droll voice, he adds, "I know that you are all dying to know. Well, it all depends upon the faithfulness of that notoriously fickle companion, the Muse. Should she abandon me, there's no telling what would become of me. If someday it should happen that a drenched and bedraggled creature should drag itself to the front door of the Yale-New Haven Hospital, claiming to be the remnant, the last vestige, of what was once long ago an assistant clinical professor of surgery at Yale (albeit unpromoted for twenty-five years—and lucky, I suppose not to have been demoted), should such a one as this appear, do not, I pray, sweep the saucer-eyed wretch into the alley, but take him in, give him a bath, feed him oatmeal with a spoon, then prop him up at the operating table and let him clamp a few more bleeders before he dies."

It is hard to hear Richard Selzer now over the laughter of his audience. Later he admitted to me that he wanted to give his listeners "a lesson in style. I wanted humor—and to put the keen edge of mortality there." As in his writings, this Grand Rounds is balanced on the edge of humor and seriousness, hope and fear. It makes a joke of the slight which Selzer felt at his lack of promotion, glossing over the real pain precipitated by his colleagues' professional disregard of him before his writings made him famous. It makes sport of the risk of retirement, although Selzer is keenly aware that he may find himself exiled from surgery and blocked as a writer—and thus with no basis with which to remain professionally alive. It offers a humorous portrait of him as an outsider, although he always feels himself a pariah, a mutant genus in the hothouse of surgery. For Richard Selzer, this humor is facade, bravado, felt, essential. It allows him to whistle in the dark.

"How do I feel?" Selzer asks rhetorically. "I am somewhere between contentment and longing—where all of us are, really, if we but delved into our souls." Selzer tells his audience how much he will miss them—but how weary he is of the "wintry kind of life" a surgeon must lead, exiled from "sunny afternoons amidst the whole and the healthy."

He is aware also of the hidden irony in all this, of retirement as a symbolic death which often leads to a literal death. His way of confessing this is characteristically poetic. He informs his colleagues: "Nearby where I live is a park with a small river where swans live. I often to go watch them deal with the water that is their bed and bathtub and pantry. I always think they are watching their own reflection out of the corner of an eye. . . like surgeons." Selzer waits for the laughter to die. "Swans are vain too. I would be if I looked like that. Perhaps a swan cannot live in the absence of his reflection. The moment it is gone, he begins to die, and knows it, and for the first time in his life he sings. Perhaps that is what is happening to me." It is a poignant moment for both speaker and listeners.

Retirement

Selzer talks of his reasons for retirement, indulging along the way in his

love of words, drawing attention to unusual or technical terms that he has found or created: "disembosom," "vaccimulgence," "Schwan und Ganz" (or "Swan and Gans, as we say," Selzer remarks, sharing an insider's joke with his colleagues). He writes the various words on the chalkboard at times during his talk, playing teacher to the amusement of his students, his white coat swirling as he hastens back and forth.

He talks of his intentions to "confront my readership, present myself and my work at colleges and medical schools as Exhibit A, living proof that you can have one leg in medicine and the other in literature." He confesses to tiredness, to the desire to recapture his youth. "In the context of retirement, I am a mere stripling of fifty-six. And so people say to me: 'But you are not old enough to retire. You are too young.' Now to one who has not heard news of his excessive youth for some thirty years, that phrase 'too young' has a lovely ring."

The humor here is indeed facade. Selzer is tired. Surgery with all its complications—its internecine rivalries, medical team stresses, hospital politics, patient deaths, weekend hours, urgent phonings—has worn him down. Although he does not yet know it, he will be called later this very afternoon to perform an emergency operation on an 18-year-old boy with a bleeding ulcer. Tired though he may be, he will drive back to Yale-New Haven and work for three hours to stitch a boy's hold on life.

We were slated after that to attend a party at Ezra Stiles College at Yale, but by the time Richard Selzer returned he could muster only enough energy to call for a pizza and relax at home. A few nights later, while we worked together at his home on some manuscripts, we were interrupted by telephone, as is so often the case. "You see," he complained to me, "how it is." In this case the caller was a woman, greatly upset. No patient herself, she had been hurt by someone—surgeons, anesthetists, hospital—and had called for advice and support. For twenty minutes Richard Selzer listened and sympathized as she described the cruelties. He encouraged her to write letters, make phone calls, meet with those responsible. "You may not know that I am retiring as of January 1st," he finally told her wearily toward the end of their conversation. "The kind of outrage you have suffered this one time I have experienced over and over for thirty-one and one half years." His voice is tired. There is no victory here.

Richard Selzer does not sleep well. "I hear the clock chime at two," he said to me, explaining part of his reason for retiring. "I am awake four hours before I get up for work." His mind is a carnival. "I am never bored. No matter where I am I find something of interest—bells, balconies, abattoirs.

"At night, my mind is so active. It is always high noon in there. I try to slow it down, try not to think, but on it goes. Ground is covered; whole planets are covered. I suppose writing is a vent for all that pressure." He paused. "After January 1st, exhaustion is *out, verboten.* We," he said royally, "are going to be energetic." He often scribbles ideas, impressions, images as they rise up before him in the restless hours before dawn. He keeps paper and pen at his bedside, along with current reading material: the plays of Christopher Marlowe, the complete short stories of Mark Twain, short studies by James Anthony Froude. Selzer once wrote in these hours, rising out of bed like a wraith to fashion "The Belly," "The Corpse," or "Abortion." No longer. The flesh weakens and the soul knows it.

'Just as the surgeon uses the sharpest blades and the most meticulously rachetted hemostats the writer uses the keenest language he can find.'

The audience in Fitkin is attentive. Selzer's Grand Rounds is at times funny, wistful, elegiac, earnest. He shifts to a discussion of retirement activities. "Up to now," he says, "I have struggled along the border between good and evil with here and there an inconspicuous lapse. So far as I know, my only two crimes are to have been born in Troy, New York and to have practiced surgery in New Haven, Connecticut." Laughter interrupts him once more. "Otherwise I have lived a blameless life. The life of a surgeon does not permit one to commit even a fraction of the sins to which the ordinary person is entitled. And some of us are really quite inspired by sin; we love it—the notion of everything caving in, a grand mess. So the first thing I plan to do after January is to go out and bust every one of them ten commandments."

A pause, and Selzer turns temporarily more serious, confessing his desire to travel, "to see things, people, all of nature, art. And I shall read the books of others." He quotes Sir Walter Scott, Edgar Allen Poe, the Bible. He writes Hebrew phonetically on the board and, before long, diagnoses Isaiah as suffering from intermittent small bowel obstruction. He admits that he will "perpetrate small writerly jokes" and then offers a pair that are elaborate puns, the most egregious of which is:

> I shall never understand, said Stanley, how it was that the organ became the musical instrument traditionally associated with religion. Long ago, it used to be the tambourine. I much prefer the tambourine as it implies a woman dancing, while an organ merely pumps up hymns.

After the laughter dies out, Selzer boldly reveals that he will "make romantic overtures" using fine phrases, then quotes Yeats and Francis Thompson as examples and says, "Now show me the woman who could resist that and I'll show you a woman whose heart is a potato—just dug out of the ground." He is warming now to his subject. "After January 1st, I shall sip a choicer wine. . . Perhaps I'll wear a poncho, let my beard grow, roll up one leg of my pants, smoke a joint or two—just to be congenial. Not that I'm for a life of sloth and idleness. Not at all. I still have ambitions—to be a pirate, for instance. Climb the rigging," he calls out gaily, waving his arms in the air, "and do a flashy thing or two with my sword. What! Never again to draw blood? The prospect is too dreary.

"In short, I shall try to live out all of your fantasies. Really, it is a service that I perform for all of you. From January 1st on you need never worry about not having any fun; I shall be having it all for you."

There is irony here. As those who know him well would testify, Selzer has little fun—at least discernibly. A typical day would find him up at 5:30 a.m., fol-

lowed by a quick breakfast and a reading of the *New York Times*, then a long day at work, home by 5:00, dinner with Janet, an hour or two of reading and possibly a bit of writing, then bed. It is the life of a hermit, an ascetic, a monk. He seldom attends parties, dinners, Yale soirees. He sees no movies, watches no television, listens to little music. Most often, Janet attends social functions by herself, with Selzer himself attending almost none whatever. I once marveled that he was able to write a book every three years while practicing surgery fulltime. "That's all I do," he responded. "I do surgery, and I write. Nothing else."

On this need for renunciation, Selzer is adamant. "Art derives from pain," he has said to me with intensity. "You tell me that most English teachers at some point wished to write. Yes, but they were not willing to suffer, and without suffering art is impossible." And so Selzer must renounce.

"What have I not given up for my art," he lamented. "Family, friends, love, children, and now my very profession—my livelihood." He is Moses and Christ, in love with his martyrdom, squeezing wine from the dried hulk of grape that is his life. In a serio-comic confession, he told me that one of his most painful renunciations was cigarettes. In May of 1984, he stopped smoking. "It was the single hardest thing I have ever done," he said in his usual melodramatic fashion. "I had begun coughing and experiencing chest pains. So I stopped. Within a week I would have given up wife, children, home, fortune for just one whiff of tobacco. In mid-September I went to Italy for a month to write. I was running away, running away from cigarettes. But it was no use. It was, indeed, worse. Everyone in Italy smokes. Cigarettes hang from balconies, peer at you from baby carriages."

But the discipline that allowed him to create stories and essays by writing in the middle of the night and during brief snatches of lunchtime in the hospital cafeteria also enabled him to renounce tobacco. Even now, seven months later, he craves a cigarette, proof of his own testimony (in "Smoking") that from tobacco "blows a very wind from paradise."

"Only one thing has kept me from cigarettes and keeps me from them still," he said to me, "and that is my writing, my art. I am not afraid of death. It holds no fear for me. But I need more time, time for books yet to be written. Only the act of writing makes this renunciation worthwhile."

In love with risk

In Fitkin, Selzer is almost finished with his list of proposed retirement activities. "I shall do volunteer surgery in whatever part of the Third World will have me," he confesses. "Peru, Honduras, and Haiti have spoken up." He tells the audience his preference would be to volunteer in America, but it is impossible. "Here, you dare not so much as administer a single aspirin without a million dollars worth of malpractice insurance. After all, the aspirin might cause gastritis, the gastritis might bleed, the hemorrhage might require surgery from which the patient might die. And outside the operating room circling, ever circling, the horde of yellow-eyed lawyers, slavering for *your* blood. Exile, then, and so be it."

'Commend me to the buckets, the linen. Pay my respects to the sink and the IV pole, the whole of that skinny race; to the masks, gowns and gloves; to the paper booties . . . '

Even as he indulges in Dickensian invective, Selzer also is expressing his interest to continue to be of use as a doctor. February of 1984 found him in Arequipa, Peru living out the life of surgery that he described in "Imelda," one of his powerful narratives in *Letters*. In fact, it was "Imelda" that led to an offer from *The London Times* for him to travel with Interplast, an American organization of plastic surgeons who volunteer their services to help Third World people. Selzer went as both chronicler and surgical volunteer. His account has now appeared in both *The London Times* and, within America, in *Vanity Fair*. Selzer does indeed plan to continue working as volunteer surgeon, even though he is nearly double the age of most volunteers and the life is dangerous for a host of reasons including eighteen-hour work days, inhospitable climates, endless dysentery, bacteria-infested food and water supplies, to say nothing of poisonous snakes and even more poisonous political clashes between government troops and rural guerilla forces.

If anything, the danger heightens Selzer's pleasure. He is in love with the thrill of it all, in love with the risk. "I possess a yen to take chances," he has said to me, "but I am totally a creature of discipline." This odd mixture of risk and discipline is characteristic. Selzer will go anywhere, try any food, talk to anyone. He has wandered the streets of Paris in the deserted hours before dawn and tread near the edge of physical and sexual assault. He has explored the Italian alps alone, straying far from his inn and returning through the mountains in darkness. He has lived alone for a month in a Benedictine monastery on an island off the coast of Venice. He is a kind of Jules Verne figure, a Dr. Nemo in search of life beneath the sea.

But he is also a writer, and so now hopes to spend most of his days sitting sedately behind a desk. For, as he tells his audience in Fitkin, "Mostly what I shall do after January 1st is write. With what a childish pleasure I shall push a pencil about a sheet of paper, crossing out words, rearranging the order of a sentence for no other reason than that I like the look of it on the page. Now and then there will perhaps be a small reminder of me—a book or an article, a story—droll or melancholy; you will catch sight of it somewhere and remember that I too passed through these corridors . . . In short, I shall pursue the mirage of Art. To do so I shall deal less in facts than in mysteries." For Selzer, this may well be the greatest risk of all—and the most exhilarating.

Selzer is, by his own admission, "fearless." How else could a man find the courage to carve open the human body by day and his own soul by night? Even this Grand Rounds fits the pattern. As Selzer admitted to me afterward, "One of the great risks I took was to give that talk. It could have alienated me from the serious, weighty side of the community. But I wanted to remind them of their own mortality—which is exactly what happened. By putting them in touch with my death, I put them in touch with their own. It was an extraordinary event in my life—and a great risk." This risk is all the greater given the long struggle Selzer has waged against the contempt of his surgical colleagues, many of whom have

considered him something of an oddity, even a crackpot. Selzer touches on this issue in the Grand Rounds.

Art within science

"It has been said by one of you, actually, that I do not tell the truth about medicine in my writings. Congratulations to him who knows for certain what the truth is and wherein it lies. I do not, and, like all other human beings, can only guess and surmise. In fact, I am not an intellectual writer, but an intuitive one. Anyone who reads my books with the idea that he is going to improve his health or learn the ins and outs of surgery is sorely mistaken. All my reader can possibly come away with is a hint, a suggestion, a certain feeling about mortality.

"Quite simply, what I do is what Adam must have done in the Garden of Eden—to gaze upon the everyday sights and events of surgery as though I were seeing each one for the first time. The Adamic act then of naming things: 'This is a squirrel, and this, an orange; this is a liver,' I say, 'and this an ovary.' I have placed these organs and objects in a special room of the mind, under a dreaming private light, and tried to see each of them in a new way. It is an attempt to discover the quintessential uniqueness of each of these things. Thus, the skin and not the brain becomes the organ of recollection, of memory, as it remembers the touch of a lover. And a perforated peptic ulcer becomes the hole through which pours all of the rage and despair that a human being can harbor. Just as the surgeon uses the sharpest blades and the most meticulously ratchetted hemostats the writer uses the keenest language he can find. In surgery it is the human body that is taken in for repairs; in writing, it is the whole world that is being reconditioned."

In essence, Selzer here has provided the essential defense of his work. His particular genius is to bring the gift of renaming into the world. He wants us to re-see the world, to conceive of surgery as eucharist, body as the ark of the covenant, patient as Christ. He shows us the grotesque inevitability of death and makes us laugh through gritted teeth at our own mortality. He presents us with a patient who becomes a miracle, demonstrating our own miraculousness by direct extension. Always he views the world as if seeing it on the first morning of creation. His is a prelapsarian vision, founded on innocence, searching for a redemption that is implied but never quite found. He is atheist and Catholic mystic and Jew; he is scientist and humanist, prophet and healer. As he put it so well in the lead essay of *Mortal Lessons*, "Did you ask me why a surgeon writes? I think it is because I wish to be a doctor."

Selzer became a doctor by default—but in his case the default was his father's. A general practitioner in Troy, Julius Selzer proved himself a failed doctor in inverse proportion to his success as a father. Richard Selzer has written a tender and humorous account in "Down from Troy" describing his father's use of bee venom and diathermy treatments, to say nothing of his homemade nostrum for eradicating athlete's foot. Of the latter, Selzer writes: "The first seven patients upon whom Will's Foot Balm was smeared developed a relentless and painful exfoliative dermatitis of the toes. Malpractice suits were not yet a la mode. The settlement was more direct. And one day Father returned from his office with a swollen lip and blood at the corners of his mouth. In his hand he carried one of his incisor teeth. To my knowledge Will's Foot Balm was never again applied to living flesh."

> Selzer is the surgeon who celebrates the art embedded within science, the doctor who washes first blood and then ink from his hands.

Selzer's image of his father as medical and financial failure catapulted the son into surgery. Julius was a warm and loving man unable to support his family, a man who almost literally died from guilt and personal mortification. He must be redeemed by the son who would re-fashion himself as the successful doctor his father could never be. Richard Selzer did just that—and yet, because of his continuing adoration, Selzer could not succeed too greatly or risk undermining the very man whom he celebrated and to whom he dedicated *Letters to a Young Doctor.*

One of Selzer's great accomplishments was maintaining a precarious equilibrium between triumph and failure. His sensitivity to failure is one of Selzer's great gifts to the history of science. As Ferenc Gyorgyey, research librarian in the Yale Medical Library who has helped Richard Selzer find various medical histories, commented perceptively: "What differentiates Richard Selzer, what makes him unique, is the way he looks at medical history. Some writers look at factual history, some at social history. Richard Selzer's individual point of view is that he has a deep personal understanding and sympathy for those who were wrong, those who failed." The source of this compassion can be traced to Selzer's complex emotional allegiance to the father who boiled gallons of foot balm on the kitchen stove in Troy.

Selzer's love of surgery is obvious to anyone who has read his work. He has celebrated his patients, written rapturously of the scalpel, sought to heal with his words. But he has never quite felt himself to be a surgeon; rather, an actor, a poseur, an imposter. In his most recent published collection, Selzer included a long, confessional story entitled just that, "Imposter," which according to his own admission "is the best thing I've ever written."

Critics have praised the story as well, which chronicles the experiences of an exile, mysteriously named N., who is part healer, part mystic. N. is tender, knowledgeable, loving. An epileptic, his suffering binds him to his patients, allowing him to divine their pain and exorcise it. Alienated, alone, martyred, fleeing, pierced with guilt—N. is a dramatic representation of Selzer himself.

"I gave him three things," Selzer explained to me, "intuition, compassion, and mechanical ingenuity. That's all he needed. He didn't need to go to medical school. And he was also wounded—without pain it couldn't be done. So I gave him epilepsy, seizures so that he could marshall his intuitive forces and apply his insights to the people." Selzer looked up, pain still in his own eyes. "I fell in love with N. I would think of him at night in my bed, but I could not name him. When he died, I could not leave it alone. So I resurrected him, made a god of him. I brought him back in a certain way."

Like N., Selzer is part doctor, part patient. Like N., Selzer finds that doctoring has never quite fit, and because of that has become one of the most sensi-

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tive and compassionate of all practicing surgeons. "Every move I have made with the knife," he has said to me, "I have questioned within myself. I cannot slaughter purely like men in the abattoir. That has been both my curse and my blessing." "Imposter"—the word conveys a great deal about Selzer's life and work.

Surgeon and writer; this is a theme Selzer returns to during his Grand Rounds. "Surgery has infiltrated every sentence that I write," he informs his audience. "All the images are related to it somehow—tactile, sensual. For instance, the Hudson River at Troy is a deep and waveless pool. All along the banks, oak, elm, and locust trees have grown very tall. The most beautiful are the locust trees. The bark of the locust is thrown into deep folds that hang about the trunk coated with lichen and green moss. So old are these trees that, without the least breeze, one will drop off a quite large branch as if to shed part of its burden. This letting-fall doesn't seem to do the tree any harm. It is more an anatomical relinquishment of a part so that the whole might remain healthy. Much as a diabetic will accept amputation of a gangrenous toe in order that he might once again walk upon his foot. How clever of these locust trees to require no surgeon for their trimmage, only their own corporeal wisdom."

In the short stillness that follows this line, the surgeon to my right acknowledges his surprise at this image with an unconscious grunt of appreciation. But Selzer, never willing to let well enough alone, looks up slyly and in a tone of confidentiality declares, "You won't find that in Norman Mailer." Laughter erupts in Fitkin Amphitheatre. Eloquence and wit, style and humor—Selzer's trademark as writer is to create the same tension of oppositions in his prose that have metabolized his life for thirty one and a half years.

"The function of literature," Selzer continues, "it seems to me, is to give mankind the wherewithal to live better. It can enlarge, inspire, console. And it has the advantage of a gold tooth in a man: it gives a woman that extra shiver of opulence while she is being kissed.

"As for my sentences, I wish that they may love each other as they are to lie together until the last of my books is destroyed. How long that will be I do not know. The magic, if any, is not in me; it is in the words themselves. Still, there is something like the arrogance of the surgeon in it. When I reread years later a paragraph of mine that I have crafted well, I know that I have made it with my heart and my hands, turned it over in my mind a thousand times. And then I rejoice and take pride. I can only ask that the finished page will have the ghost of wholeness, the way that ashes sometimes keep intact for a time the shape of the log that made them."

Ending and beginning

Richard Selzer is ending his Grand Rounds, suturing the incision that laid bare his heart to colleagues and friends. He reaches back now toward the beginning of his talk to reestablish key themes. It is the literary move of a writer trained in the classical rhetorical tradition of Virgil and Longfellow.

"It is less than two weeks from the day of my leaving," he says. "Turn aside if you should see me slink one night to take a final look at the operating room which has been for me both prison and sanctuary. Let me confess it: there is heartache in this farewell. On January 1st, when you go there to work, commend me to the buckets, the linen. Pay my respects to the sink and the IV pole, the whole of that skinny race; to the masks, gowns and gloves; to the paper booties. To the women who have scrubbed alongside me all these years, with their deep wells of humor and affection, who have bolstered and rescued me and, after calamity, consoled.

"I have been happier in these rooms than anywhere else. And sadder too. So much of the blood shed there has been my own. Ruinous to some, the salvation of others—the operating room is a special place, a perfect blend of the sacred and the profane. Weary though I am at every leakage of blood, every blockage and perforation, it is hard to leave. For this is my shop, my workbench, my barn, the garage where in my own small way I have taken the human body in for repairs. I try to congratulate myself on having obtained, before I am superannuated, the 'peaceful hermitage of retirement.' And I do. But still . . .

"Where is it graven in stone that once having been ordained a surgeon, one must stand at the operating table until the scalpel slips from my lifeless hand? I have no wish to be propped there, my arthritic fingers plaited about a knife. I am no old lion whose claws are long since blunted but not the desire to use them. Still, still, with rue my heart is laden. What! Never again to lower into the magic landscape where I have sought adventure and satisfaction for three decades. Never again to part the body's foliage, peering for signs, listening for the whisper of tissue. No more the camaraderie of the locker room, the quiet donning of special raiment, the priestly washing of hands, the murmuring tactile pedagogy of surgery in which the secrets of this work are passed on from hand to hand. It is goodbye to all that."

Richard Selzer stops, waits, as if listening. "And when I am not writing or traveling or doing volunteer surgery in the Third World, or going about from podium to podium like this," he states, "why you can find me down on the Green playing checkers with my new colleagues. Come on over at lunchtime, and I'll play you a game or two.

"And so I be the bastard offspring of Medicine and Literature which signs itself 'Yours Faithfully, Richard Selzer.' Thank you."

It is over. We all celebrate this performance with applause, but it seems somehow sacrilegious, like clapping at a funeral. One of the residents whom Selzer trained, Mary Gregg, is invited forward and speaks of how extraordinary a teacher Selzer is, how important he has been to generations of medical students. She gives him a fine pen set, tools for his craft. There are tears in her eyes.

Others come forward as the audience begins to disperse. There are farewells, hugs, handclasps. Finally Richard Selzer departs. Later in the week there will be a formal reception honoring him in the Beaumont Room at the Yale Medical School Library. As for now, he and I drive homeward. Once there, Selzer retires to rest, and I wander through the lovely colonial home, ending up before a fine stained glass window on the second floor. Its image is of a barefoot maiden, brown tresses cascading down her back. She is perched at the very edge of crags overlooking a deep, green river valley. Glancing downward, she grasps a lyre which is plucked by her right hand. She is a poet, a singer of words. One misstep and she will plummet to her ruin, but her very precariousness seems to spur on the creative impulse. She sings. In the next room, Selzer rests, readying himself for the artist's life that lies ahead. □

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C: INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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physicians in the news

Harold M. Weiner, MD, left, and Eugene B. Rex, MD, were installed this summer as officers for Montgomery County Medical Society. Dr. Weiner is president and Dr. Rex is chairman of the board of directors.

Bernard Sigel, MD, was appointed chairman of the department of surgery at Medical College of Pennsylvania (MCP). Dr. Sigel most recently served as professor of surgery and chief of the division of biomedical engineering at the University of Illinois College of Medicine, Chicago. He was dean of MCP from 1969 to 1974, as well as MCP's acting president from 1971 to 1974. Dr. Sigel succeeds **James G. Bassett, MD**, who retired after serving 30 years on the medical school's faculty.

Jennifer Allcock, MD, received the Philadelphia Award, given annually to an outstanding city resident who has contributed to the best interests of the community. The award, which was established in 1921 by the late Edward W. Bok, was presented by **Maurice C. Clifford, MD**, chairman of the board of trustees of the award. Dr. Allcock was a principal founder of Covenant House Health Services, a nonprofit health care organization that provides a broad range of outpatient health and social services for people regardless of their income status. Dr. Allcock serves as executive director and medical director of the organization. She also is clinical assistant professor of pediatrics and community and preventive medicine at the Medical College of Pennsylvania.

The Pennsylvania Chapter of the American College of Utilization Review Physicians elected new officers at its annual seminar. They are: **William Zavod, MD**, Philadelphia, president; **Joseph J. Trautlein, MD**, Hershey, vice president; **Arthur C. Schneck, DO**, Erie, secretary; and **Thomas J. McBride, MD**, Upland, treasurer.

The American Diabetes Association presented the Upjohn Award for Outstanding Educator in the Field of Diabetes to **Charles Shuman, MD**, Jenkintown. Dr. Shuman is professor of medicine at Temple University School of Medicine.

Ralph J. Caparosa, MD, received a first place award for his slide presentation on "Steroscopic Surgical Anatomy and Techniques of the Temporal Bone," shown at the 13th World Congress of the National Otolaryngology Academy of Miami. Dr. Caparosa is an otolaryngologist at Eye and Ear Hospital, Pittsburgh.

The Board of Directors of Montgomery County Medical Society honored retiring board member **Frank J. Tornetta, MD**, Norristown, for 25 years of service to the society. Dr. Tornetta has held a series of elected positions in the county society since 1959, when he served as treasurer, and he has been chairman of the board since 1976. Dr. Tornetta is chief of anesthesiology at Montgomery Hospital.

William E. DeMuth Jr., MD, has received the Walter J. Thomas Award of the Pennsylvania Emergency Health Services Council. It was presented at the council's Eighth Annual Awards Banquet, held this summer.

Stuart E. Price Jr., MD, Pittsburgh, was voted president elect of the American Urological Association at its recent meeting in Atlanta.

Leonard Jarett, MD, Philadelphia, received the Ernest Cotlove Award from the Academy of Clinical Laboratory Physicians and Scientists. The award recognizes scientific achievements in pathology and laboratory medicine. In addition to receiving a certificate, Dr. Jarett gave the Cotlove Lecture at the organization's annual meeting in June. Dr. Jarett is chairman and Simon Flexner Professor of Pathology and Laboratory Medicine at the University of Pennsylvania School of Medicine. He is chairman of the department of pathology and laboratory medicine at the Hospital of the University of Pennsylvania.

Myron Yanoff, MD, Philadelphia, was a guest lecturer at the Thirteenth World Congress of the Israel Medical Association in May. Dr. Yanoff is director of

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Scheie Eye Institute, Philadelphia, and is chairman of the departments of ophthalmology at University of Pennsylvania School of Medicine and Presbyterian-University of Pennsylvania Medical Center. At the congress, he presented papers on various topics in ophthalmology.

Paul C. Brucker, MD, Ambler, has been appointed chairman of the Part II Preventive Medicine and Public Health Test Committee of the National Board of Medical Examiners. Dr. Brucker is Alumni Professor and chairman of the department of family medicine and clinical professor of medicine at Jefferson Medical College of Thomas Jefferson University.

Two physicians from The Children's Hospital of Philadelphia were awarded grants from the Ethel Brown Foerderer Fund For Excellence. **Leslie N. Sutton, MD**, assistant neurosurgeon will develop a program for basic clinical research into management of children with brain and spinal cord tumors. **Haewon C. Kim, MD**, director of the blood bank, donor center, and transfusion unit, will develop a new service, therapeutic apheresis.

Stanley Baum, MD, Philadelphia, was named to the Institute of Medicine. Dr. Baum, a professor and chairman of the department of radiology at University of Pennsylvania School of Medicine, and the Hospital of the University of Pennsylvania, was selected for his contributions to the fields of health and medicine. The institute was chartered in 1970 by the National Academy of Sciences to enlist distinguished professionals to examine policy matters pertaining to public health.

Herman Beerman, MD, Philadelphia, received the Stephen Rothman Memorial Award given by the Society of Investigative Dermatology at its recent annual meeting in Washington, DC. The award is given for service to investigative cutaneous medicine. Dr. Beerman is emeritus professor of dermatology at University of Pennsylvania School of Medicine.

Ronald B. Herberman, MD has been appointed director of the Pittsburgh Cancer Institute, a joint effort of the University of Pittsburgh, the six hospitals of the University Health Center and Carnegie-Mellon University. Dr. Herberman previously was chief of the biological therapeutics branch of the biological response modifiers program, the National Cancer Institute.

The new Cardiac Care Unit at Crozer-Chester Medical Center was named for **Herman Gold, MD**, who was instrumental in the development of cardiology at the medical center. Dr. Gold was chief of medicine at Chester Hospital from 1950-1963, and director of Crozer-Chester Medical Center's division of cardiology from 1972-1974.

PMS President D. Ernest Witt, MD, administered the oath of office to leaders of the Pennsylvania Society of Medical Assistants. Shown above from right are Dr. Witt, Mary K. Shay, Bradford County, treasurer; Teresa Lombardo, Allegheny County, recording secretary; Debbie Begg, Allegheny County, president elect; Ruth Fitting, York County, vice president; Ruth Ann Orr, Lawrence County, vice speaker; Maxine N. Johnson, Blair County, speaker; and Alice M. Henrigan, Lackawanna County, president.

David R. Brill, MD, vice chairman of the Society's Commission on Therapeutic and Toxic Substances, has been appointed to the Public Advisory Committee on Low Level Radioactive Waste.

Joseph S. Gonnella, MD, dean and vice president of Jefferson Medical College of Thomas Jefferson University, has been appointed to serve on committees of three professional organizations. Dr. Gonnella is serving a one year term as a member of the Committee on the Study of Evaluation Procedures of the American Board of Medical Specialties; he is serving a two year chairmanship of the Nominating Committee of the Association of American Medical Colleges; and he is serving a one year term as a member of the Academic Health Center Work Group of the Joint Commission on Accreditation of Hospitals.

A resident in ophthalmology, **Stephen E. Orlin, MD**, Overbrook Hills, won the award for "Best Resident Paper of the Year" from the department of ophthalmology of the University of Pennsylvania School of Medicine and Scheie Eye Institute. The award was presented at the annual meeting of the University of Pennsylvania Alumni Ophthalmological Association. Dr. Orlin's paper was on "Retrobulbar Hemorrhage—the Mechanism of Loss of Vision and its Management."

William H. Spivey, MD, Philadelphia, has been awarded a $25,000 research scholarship by the American College of Emergency Physicians. The scholarship is one of four national awards offered for the first time by the college. It will allow Dr. Spivey to continue his research in the use of beta blockers in myocardial infarctions. Dr. Spivey, who recently completed his residency in emergency medicine at the Medical College of Pennsylvania (MCP), currently is instructor in the department of emergency medicine at MCP, and co-director of the department's research activity.

The New Wilmington Rotary Club presented its Citizen of the Year award to **Howard L. Shaffer, MD**, for service to the community and professional leadership. Dr. Shaffer, a general practitioner who still makes house calls, is active in the Rotary Club and has served on the Wilmington Area School Board. He is a former president of the medical staff of Jameson Memorial Hospital.

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obituaries

• *Denotes PMS membership at death.*

• **Frank J. DiLeo,** Allentown; New York University School of Medicine, 1930; age 81, died May 30, 1985. Dr. DiLeo specialized in urological surgery.

• **John J. Domanski,** Philadelphia; Hahnemann University School of Medicine, 1931; age 79, died May 23, 1985. Dr. Domanski maintained a general practice in Philadelphia for more than 50 years.

• **Leonard E. Egerman,** Oakland; University of Pittsburgh School of Medicine, 1929; age 79, died June 20, 1985. Dr. Egerman was a psychiatrist.

• **Milton I. Engel,** Erie; University of Toronto Faculty of Medicine, Ontario, 1943; age 65, died June 13, 1985. Dr. Engel practiced medicine in Erie for 30 years, specializing in allergy and immunology.

• **Howard Taft Fiedler,** Hallandale, Florida; Hahnemann University School of Medicine, 1930; age 76, died June 3, 1985. Dr. Fiedler was former superintendent of Allentown State Hospital.

• **Joseph E. Gable,** Reading; Temple University School of Medicine, 1943; age 67, died June 11, 1985. Dr. Gable was a general practitioner.

• **Stanley Green,** Melrose Park; Temple University School of Medicine, 1948; age 60; died May 4, 1985. Dr. Green specialized in the treatment of cardiovascular diseases.

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• **Joseph A. Hepp,** Point Breeze; University of Pittsburgh School of Medicine, 1925; age 85, died June 5, 1985. Dr. Hepp specialized in gynecology.

• **Edward J. Kielar,** Glen Lyon; Loyola University of Chicago Stritch School of Medicine, 1926; age 87, died April 18, 1985. Dr. Kielar served on the staff of Nanticoke State Hospital from 1925 until his retirement in 1983.

• **Arthur J. McSteen,** Pinehurst, North Carolina; Jefferson Medical College of Thomas Jefferson University, 1934; age 76, died May 31, 1985. Dr. McSteen practiced internal medicine in Greensburg and was a member of the Westmoreland Hospital staff for 41 years.

• **Morton Maurice Medvene,** Glenside; University of Pennsylvania School of Medicine, 1938; age 74, died May 23, 1985. Dr. Medvene was a general practitioner.

• **Clarence E. Moore,** Harrisburg; Queen's University Faculty of Medicine, Ontario, 1927; age 83, died June 25, 1985. Dr. Moore was a member of the surgical department at Harrisburg Hospital and a past president of its staff.

• **Jacob Reber,** Bala Cynwyd; University of Pennsylvania School of Medicine, 1932; age 78, died May 11, 1985. Dr. Reber specialized in ophthalmology.

• **Gordon L. Renton,** Mt. Lebanon; University of Pittsburgh School of Medicine, 1942; age 78, died May 20, 1985. Dr. Renton, a plastic surgeon, graduated from University of Pittsburgh's medical and dental schools.

• **Harry E. Shaw,** Glenshaw; University of Pittsburgh School of Medicine, 1935; age 78, died May 2, 1985. Dr. Shaw was an ophthalmologist.

• **Albert M. Starr,** Erie; The Ohio State University College of Medicine, 1957; age 62, died April 28, 1985. Dr. Starr served as chief of the department of anesthesia at Saint Vincent Health Center, Erie, for 15 years.

• **Jack Strassman,** Altoona; Temple University School of Medicine, 1939; age 72, died May 29, 1985. Dr. Strassman was an internist.

• **Irving B. Wexlar,** Philadelphia; University of Pennsylvania School of Medicine, 1943; age 66, died May 18, 1985. Dr. Wexlar was a member of the team of radiologists at the former Doctor's Hospital in Philadelphia that perfected a quick method of diagnosing rheumatic fever.

Donald Saul Fiegenberg, Bensalem; Jefferson Medical College of Thomas Jefferson University, 1962; age 48, died April 3, 1985. Dr. Fiegenberg specialized in rheumatology.

Spencer S. Lebengood, Harrisburg; age 71, died May 14, 1985. Dr. Lebengood was a general practitioner.

William L. Martz, Steelton; Philadelphia College of Osteopathic Medicine; age 61, died May 2, 1985. Dr. Martz was former chairman of the medical staff at Community General Osteopathic Hospital.

Marilyn Elva Moyer, Shamokin; age 46, died May 8, 1985. Dr. Moyer was an ophthalmologist.

Joseph Venuto, Drexel Hill; Philadelphia College of osteopathic Medicine, 1947; age 73, died May 24, 1985. Dr. Venuto was on the staff of Metropolitan Hospital, Springfield, for 25 years.

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Roller injury to the upper extremity

Robert K. Finley, III, MD
John M. Parenti, MD, AAOS
Gerald Gordon, MD, FACP
Sheldon Brotman, MD, FACS

The term "wringer arm" was coined by MacCollum[1] in 1938 to describe the injury resulting from traction applied to an extremity being drawn forcibly through the moving rollers of a non-automatic washing machine. Many reports since that time have documented both this injury and its high energy variations such as "cornpicker,"[2] "power take-off,"[3] and "hay baler roller."[4] This type of trauma is characterized by compressive, avulsive, and friction heat forces acting on the extremity to produce degloving of skin and myonecrosis. The histological manifestations include edema, capillary stasis, and obstruction to capillary blood flow.[5]

Although the injury is by no means new, a recent industrial roller injury treated by our trauma service has refocused interest on this lesion. Since the last major review of this subject in 1972,[6] sufficient advancement has been made to warrant additional commentary.

Case report

A twenty year old man caught his dominant (left) upper extremity in a set of industrial rollers. These were set at a width of one-half inch and were capable of exerting more than 800 pounds psi. The patient's left arm was drawn through the rollers up to the mid-biceps area. He was entrapped for several minutes.

On physical examination, the patient's blood pressure was 220/80 mmHg and his pulse was 82 per minute. Skin was degloved on the ventral and dorsal sides from the middle biceps area to the mid palm. The thumb was completely dislocated at the metacarpophalangeal joint with absent sensation, cyanosis, and minimal motor function. Neurovascular status of all the fingers was intact. A five centimeter laceration was present at the base of the palm.

X rays disclosed a complete metacarpophalangeal dislocation of the thumb, a midshaft fracture of the fourth metacarpal, and segmental fracture of the fifth metacarpal at the level of the neck and base with carpometacarpal dislocation. There were no fractures of the elbow or arm. Angiography of the extremity showed no major vascular impairment.

Following the initiation of one gram of cefazolin, an intravenous infusion containing 50 mEq sodium bicarbonate and 25 gm of mannitol per liter was begun for prophylaxis of renal toxicity secondary to anticipated myoglobinuria. Tetanus toxoid was administered along with tetanus immune globulin, and a Foley catheter was placed. The patient's hematocrit was 31 percent and his serum electrolyte levels were within normal limits with a BUN of 14 and a creatinine of 0.9.

The patient was taken to the operating room where debridement of necrotic skin and muscle was carried out. Fasciotomies of the dorsal compartment, and both superficial and deep groups of the volar compartment were performed. Open reduction, internal fixation of the dislocated first metacarpal phalangeal joint, and the fourth and fifth metacarpal fractures was accomplished using Kirschner wires.

For the first 48 hours after surgery,

The authors are from the trauma and orthopedic services of Geisinger Medical Center.

Figure 1 The injured extremity is shown following serial debridement of devitalized skin and muscle.

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2-D and Doppler Imaging
Moderator: *Gary S. Mintz, MD*
3 p.m.

Case Presentation: Mitral Stenosis—*Mark F. Victor, M.D.*
Discussion—*Ioannis P. Panidis, M.D.*
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the patient's urine output was maintained between 100-200 cc./hr. using the previously mentioned IV solutions. The urine remained clear throughout the postoperative course and was negative for myoglobin. The patient returned to the operating room on postoperative days two, four, and seven for serial debridements and dressing changes. On postoperative day two, a small irrigation catheter was placed in proximity to the exposed brachial artery to prevent desiccation. On postoperative day four, an IV bolus of fluorescein dye was given and the viability of the skin was assessed using a Wood's lamp to appreciate areas of skin at risk for future necrosis. Debridement was conservative and based on clinical judgment of tissue viability.

Because of frequent trips to the operating room, the patient was NPO for a significant period of time. A serum albumin level of 2.2 gm/dl (normal 3.0-5.6 gm/dl) and serum transferrin of 117 mg/dl (normal 204-306 mg/dl) on the sixth postoperative day reflected a significant degree of nutritional impairment. In anticipation of further procedures, a subclavian catheter was placed to give parenteral nutrition. He was given approximately 3,400 calories per 24 hours via this route. A small diameter NG tube of the Dobbhoff variety was placed later for enteral supplementation.

By the 11th postoperative day, a viable base for grafting was present and split thickness skin grafts were applied to the forearm; a full thickness graft was applied to the palm of the hand. A 90 percent take was obtained.

Discussion

In 1966, 13.3 percent of all washers in this country were non-automatic wringer type machines.[6] The associated injury was typically a mild friction burn with erythema and mild to moderate edema that could be satisfactorily treated in many cases with elevation and compressive dressings. In the series by Edgerton *et al.*[6] consisting of 100 consecutive "wringer arm" patients, only fifteen required grafting for replacement of full thickness skin necrosis. In a collected series of 3,370 patients only three required fasciotomy. Five Volkmann's ischemic contractures were observed in this same group.

More energy can be applied in similar types of injury sustained in the industrial setting. The power take-off is an extension of the drive shaft of a motor vehicle and is the major source of power for most farm implements such as corn-pickers, elevators, and blowers. The kinetic energy level involved in power take-off injury is more than three times that of a 357-magnum pistol.[3] The hay baler roller can generate more than 1,300 pounds of pressure between its rollers.[4] The upper extremity roller injuries of the 1980s can be expected to be more commonly associated with this level of energy.

The basic evaluation of roller injured patients should be rapid and aggressive. Resuscitation with attention to airway, breathing, and circulation are primary priorities. Laboratory studies consisting of hemoglobin, electrolytes, and arterial blood gases should be obtained in addition to BUN and creatinine. The latter values will serve as important baselines for the evaluation of renal function in the face of myoglobinuria later in the patient's course.

Radiographic evaluation should consist of an upright chest x ray and appropriate views of the injured extremity. At the same time, depending on the severity of the injury, the physicians should consider the need for angiography, bearing in mind that the intravenous dehydration caused by the injection of angiographic dye may aggravate

the risk of renal failure in the patient with significant myonecrosis and delay operative therapy.[10] It is important to give intravenous fluids at a level which will be tolerated by the patient's cardiovascular system but will also maximize the urinary output at a level of 100-150 cc/hr. Sodium bicarbonate and mannitol may be given with intravenous fluid to prevent renal toxicity secondary to myoglobinuria.[11,14] A Foley catheter is essential in the first 24-48 hours to monitor the urinary output.

In severe crush-burn injury, we believe that a surgical team consisting of orthopedic, general, and plastic surgeons provides the best approach. The most difficult aspect of treatment involves the evaluation of muscle and skin flaps. Tissue damage in roller injury depends on the space between the rollers; the speed of cylinders; the hardness of the roller surface; temperature of the parts; and how hard the patient struggles to free himself.[4] Evidence of the extent of injury may not be apparent upon initial examination. In an experimental study of wringer injury, Adams and Fowler[5] used rats to demonstrate the first histologic evidence of injury did not become manifest for three to five hours and reached its maximum twenty-four hours after the injury. The status of the compartments of the extremity must be evaluated. If elevated pressures are suspected or if necrotic muscle is present, they must be opened.[7] The use of fluorescein in the determination of skin viability may be helpful, but it will assist very little in the evaluation of muscle tissue. Further, fluorescent tissue may die later due to an advancing edema, hemorrhage, or sepsis. Fluorescein demonstrates viability only during its period of use; it does not accurately predict the future. Xenon, by injection and inhalation, has been used experimentally by our group with rather confusing results and ultimately has been abandoned. The best determinant will be an experienced surgeon who had dealt with large numbers of these cases.

A conservative approach to debridement is advocated. Initially debride only frankly necrotic areas. This applies to both skin and muscle, since there is evidence that some regeneration can occur.[5] Debridement should be frequent, perhaps every other day for the first week. If the patient should appear toxic or display signs of renal failure, debridement should be done emergently. Ablation of the limb may be considered in cases of impending renal failure or life-threatening illness.

Every effort must be made to achieve stable internal fixation of fractures to avoid the necessity of postoperative immobilization and the development of contractures. The best way to gain stability is usually with Kirschner wires either by closed pinning or by open reduction.[8] Other methods of fixation including screw or plate fixation may be considered, but usually require increased operative time and greater soft tissue dissection—frequently associated with additional joint stiffness. A mini external fixator can be used to treat fractures with considerable bone loss but may interfere with dressing changes and grafting.[8]

The role of antimicrobials is secondary to an aggressive surgical debridement of devitalized tissue. Initially, antimicrobials with activity against common skin pathogens *(Staphylococcus aureus* and *Streptococci)* may be considered (e.g., cefazolin 1 gm IV q8 h) for a short period through the first debridement procedure. Since perfused muscle is rarely infected with bacteria, prolonged courses of broad spectrum antimicrobials unnecessarily alter the patient's bacterial flora, place the patient at risk of nosocomial superinfection, and offer little additional benefit over simpler approaches. Of equal or greater importance is tetanus prophylaxis. Tetanus toxoid and hyperimmune tetanus immune globulin (Hyper-tet, Cutter) should be administered in this situation as part of the initial management of roller injury.

The nutritional status of these patients is equally important. The serum albumin level of 2.2 gm/dl obtained in this case is typical. Poor nutritional status secondary to multiple periods of being NPO for surgery can contribute to this. The lethargic feeling accompanying general anesthesia in the postoperative period is another factor as well as multiple blood transfusions. In the patient with a functioning GI tract, enteral alimentation is preferred and can be supplemented by a small silastic feeding tube placed in the duodenum. If the patient must be NPO for frequent operations, then the use of hyperalimentation via central vein catheter is indicated.

Some preliminary reports indicate that hyperbaric oxygen may be beneficial in salvaging the severely crushed limb.[12] Hyperbaric oxygen may act to enhance host responses and break the vicious cycle of ischemia and swelling involved in this injury.[15] Carefully controlled clinical and laboratory data are not yet available in this area.

Reconstruction will be guided by clinical course. Wounds will best be treated initially by early coverage as soon as the soft tissues have achieved a sufficient layer of granulation tissue. This serves to decrease the level of bacterial entry.

When considering the replacement of hand skin, one must keep several principles in mind. In order for the hand to function properly, the skin envelope enclosing tendons, nerves, vessels, bones, and joints must be elastic and non-adherent containing as much sensibility and freedom of motion as possible. Dorsal skin must be thinner, more elastic, and loose enough to not restrict flexion and serve as a barrier to cover tendons and joints. Volar skin must be thicker and tougher while still maintaining enough elasticity and looseness to allow motion, and above all, it must retain sensibility. Full thickness grafts are indicated for the palm.[9] □

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'Tax simplification': effect on investment plans

Vasilios J. Kalogredis, JD, CPBC

At this point it is not clear what, if anything, Congress is going to do with all the "flat tax" and "tax simplification" proposals around. Although the recent Treasury proposals seem to be a step in the direction of answers, they only raise more questions.

While it's uncertain what's going to happen to the tax law, one thing *is* certain—the rumors, proposals, and discussions are going to have an effect on the investment community. When you make plans you'll need to keep these proposals in mind—not to second-guess what Congress is going to do, but to try to understand what other investors are going to do, and how your own investments will be affected.

Here's a look at the investments that stand to be most affected by tax simplification.

The author is a practicing attorney and president of Professional Practice Consulting, Inc., Wayne, a firm that advises health care professionals.

Municipal bonds

You may have heard people recommend you sell your municipal bonds. The idea is this:

Let's say that you currently own a 10% municipal bond. If you are in the 50% marginal tax bracket, you'd be getting the same after-tax return as on a 20% taxable bond. If the flat-tax is

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passed, and the highest bracket is lowered to 35%, that tax-exempt bond would now only give you the same after-tax return as a 15% taxable bond.

Some investors might want to run to market to sell those municipal bonds. A cut in the marginal income tax rates might lead investors to believe those tax-exempt bonds are no longer as good an investment, and the fear of a cut might drop the prices even sooner. However, chances are good that the prognosticators recommending abandoning municipal bonds aren't looking at the complete picture. This actually might be the best time to buy and hold municipals. Reasons:

- The fear of tax simplification has already occurred. In other words, the effect of the proposals, at least on the municipal bond market, has already been felt, and prices probably will not get lower from here.
- Tax-exempt bonds may become less attractive, but they will still be attractive in relation to taxable securities even if tax rates are lowered. For example, a 10% municipal bond would be equivalent to a taxable yield of over 15% if the maximum tax rate dropped to 35%—still a good investment.
- The value of bonds depends a great deal on supply. Since the proposals would knock out private activity bonds (industrial development bonds) from the tax-exempt roster, there will be fewer tax-exempts available. This too, should keep the price of the remaining municipals stable, and could even increase their value.

In short, this is not the time to leave the municipal bond market, no matter what you may be hearing.

Common stocks

There are two different ways that the new proposals would effect the value of common stocks.

The first is at the corporate level. The proposals would lower the corporate tax generally, but reduce some of the depreciation advantages of investing in plant and equipment. This means that heavy industrial businesses will suffer under the proposals while the other companies out there will flourish.

The big winners are in such industries as advertising, retailing, food distribution, publishing, and broadcasting. Some high-tech firms (those that aren't heavily dependent on equipment) will come out ahead, but the rest won't.

The losers will be manufacturing companies, many utilities, transportation, and mining. Some industries such as banking, life insurance, and pharmaceuticals, are now eligible for special tax breaks which would be repealed under the proposals, so these companies also would be hurt.

This corporate level impact is, as we've noted, in the future, but it's important to keep it in mind in the months ahead. As you see the individual proposals get formed and shaped into law, you can keep your eyes open for the possible trouble spots.

The second way the proposals would affect common stocks is at the investor level. The Treasury proposals would do away with the special capital gains deduction that now lets you deduct 60 percent of your gains if the stock is owned more than six months (or a year if purchased before June 23, 1984). Gains would be taxed at the same rate as any other income that you might get during the year. However, you won't be taxed on your entire profit, only the amount by which your profit exceeds your investment plus inflation.

For instance, if you buy some stock at $100 and sell it at $150, and in that period of time inflation has been 10 percent, you'd have a taxable gain of $40. Overall, however, for most people, the tax would be higher.

As with municipal bonds, this is another situation where the public's perception of what's going to happen may have a greater effect on prices than the actual changes themselves. And again, the public perception already may have left its mark.

But there's a major difference between the effect that public perception has on bond value and the effect that it has on stock values. The stock values are far more volatile. Many stock market experts are wary of the direction that the market can take in times such as these, when it is uncertain how these investments will be taxed.

What does this mean? It means that if you're the kind of person who tends to avoid the stock market because you feel it is risky, then you probably should stay out now. In a state of uncertainty the stock market is more volatile than ever, and at this point, you should only invest in common stocks if you can weather major changes in the value of your portfolio.

Investment real estate

Right after the Treasury proposals came out, there were several major real estate syndicators who scrapped some of their plans. The question is this: If you're looking at investment real estate, should you be scrapping your own plans? After all, if depreciation deductions for real estate are cut back, will it still make sense for you to make that investment?

In most cases, yes. Be on the lookout for the real estate deal that relies too heavily on tax benefits for its viability. However, you should be doing that anyway, since the IRS has the power to disallow your deductions if your investment depends on tax benefits to be profitable.

If you're already exercising a measure of prudence, your activities in selecting and buying real estate are fine, and shouldn't be changed on account of these proposals.

There may even be a hidden advantage in the new proposals for you. As with stock, your taxable profit doesn't include any profit that's attributable to inflation. That means if you're planning to hold onto a particular piece of real estate for a long time, you'll have a smaller tax to pay on selling it under the new proposals than under current law. Where's the break-even point? If inflation is at five percent, for instance, and the property doubles in value, then you're better off under the new proposals if you sell it after 7½ years. If you sell it before 7½ years, you'd be better off under current rules.

Other investments

The proposals shouldn't have that great an effect on most other investments. Certainly, if there's a cap on consumer interest of $5,000 (other than home mortgages), that will take the glow off of vacation homes, and insurance policies that are financed by borrowing the cash value out (the so-called "minimum deposit" arrangement). But, on the whole, municipal bonds, common stocks, and investment real estate are subject to the greatest effect.

Now's the time to be on the lookout for snake oil salesmen. These are the people who say you've got to buy this or that, because next year you won't be able to get some tax advantage or other. The contrary is true at this point. You simply can't rush into anything, or for that matter, out of anything. You have to review your investment portfolio as a whole, watch as new laws unfold, and take care not to get lost in the hysteria. □

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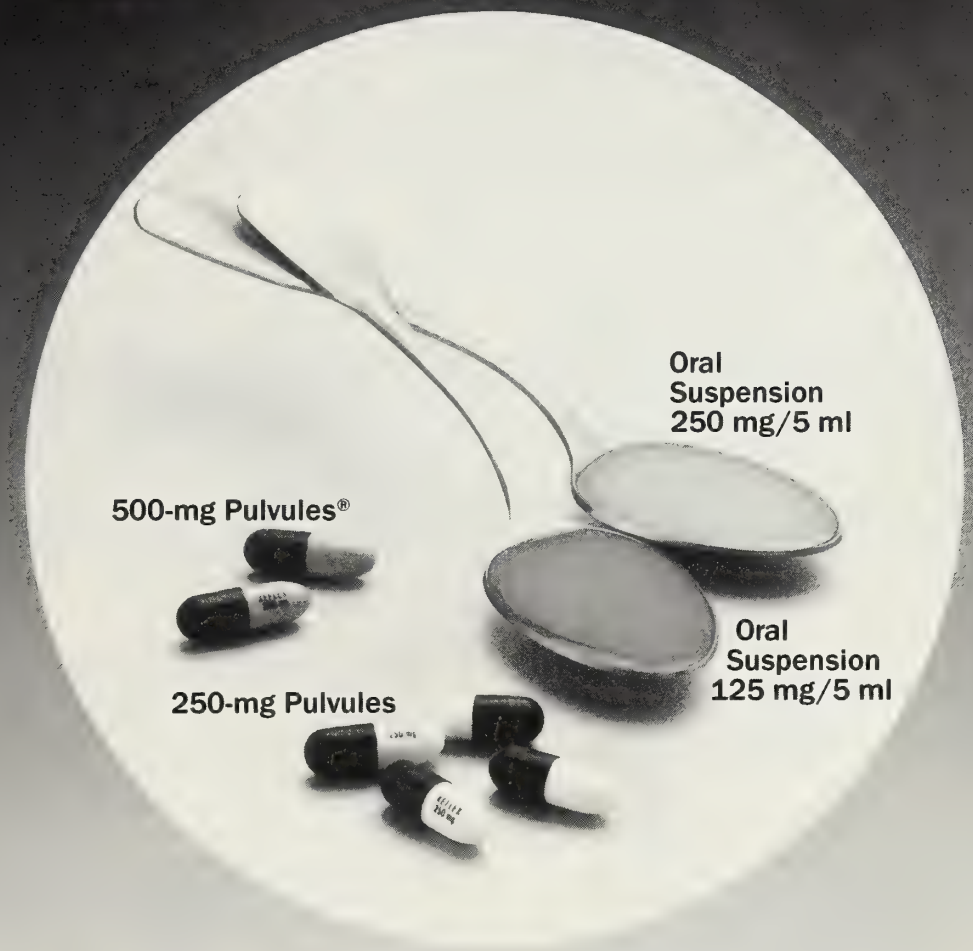

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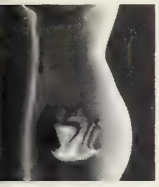

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Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS: Recommended dosage is 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

HOW SUPPLIED: *DS (double strength) Tablets* (160 mg trimethoprim and 800 mg sulfamethoxazole—bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets* (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). *Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

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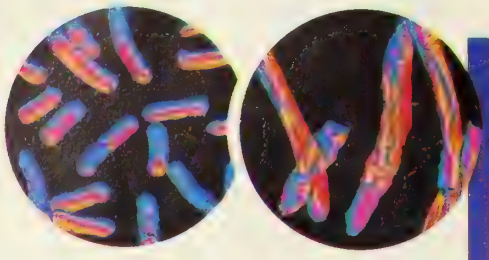

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before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

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Please see preceding page for a summary of product information

Pennsylvania Medicine

Volume 88, No. 10 OCTOBER 1985

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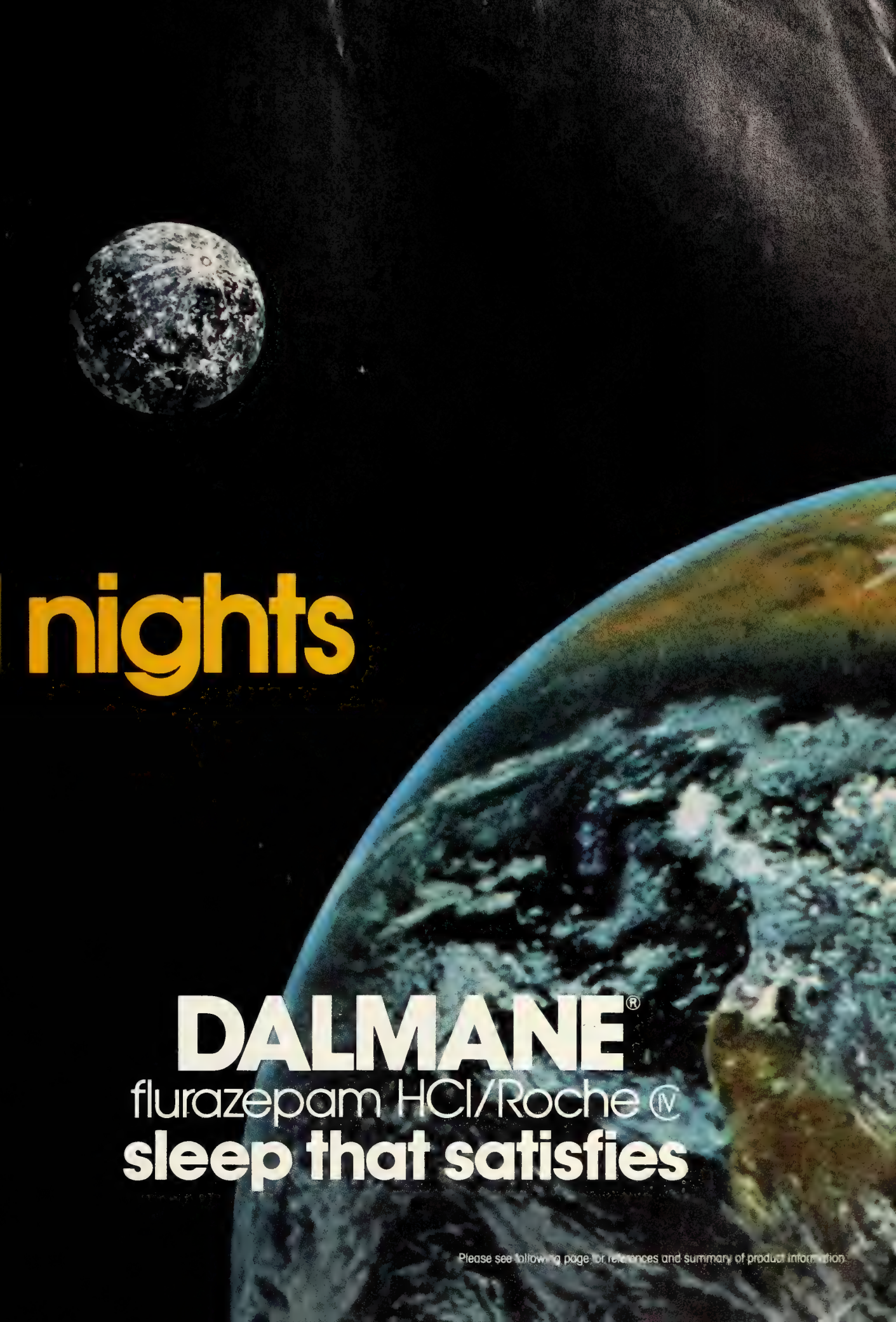
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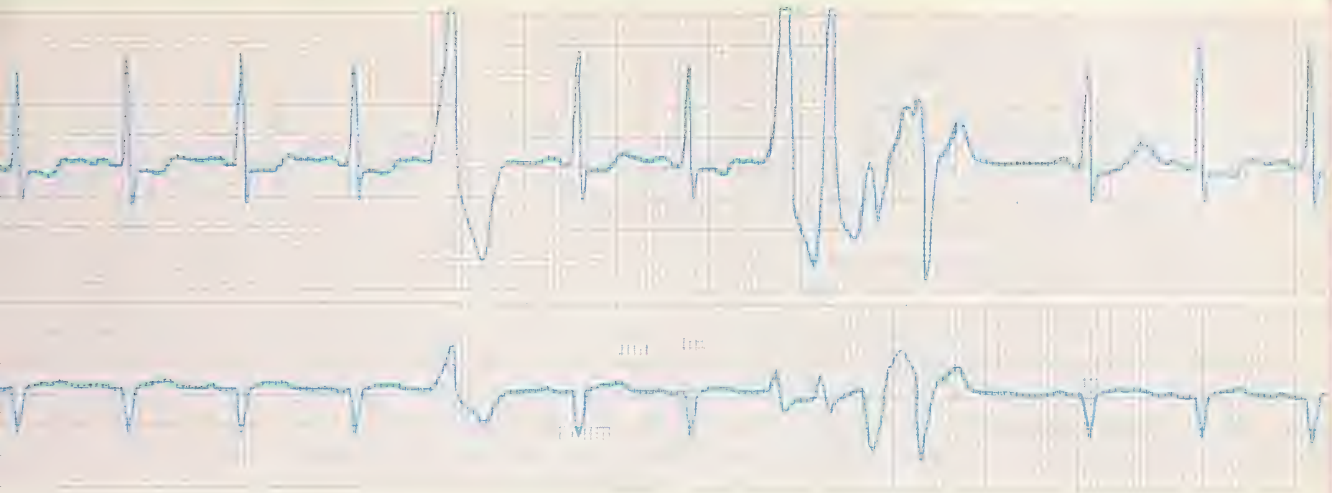

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Medical Assistance reimbursements for office visits were increased October 1 to 70 percent of average charges. The fee for a patient's visit to the physician's office or hospital emergency or out-patient departments was increased in the state budget adopted and signed at the end of June. PMS and The Hospital Association of Pennsylvania joined forces to negotiate the increase from the previous fee level, which was 50 percent of average charges. Physicians now will be paid $13 for an office visit of a patient on Medical Assistance. Previously the fee was $11.50. Physicians are cautioned to put down their actual charge for services when billing the Department of Public Welfare rather than the amount allowed. DPW cal- culates reimbursements according to a percentage of physicians' average actual charges drawn from the department's computerized data.

OARD OF TRUSTEES AUTHORIZES ENTATIVE $5.2 MILLION BUDGET

A proposed budget of $5,220,934 won the approval of the Society's Board of Trustees on September 18. The balanced budget, representing a 4 percent increase in spending over 1985, is subject to change depending on action of the House of Delegates at the 1985 Annual Business Meeting in Philadelphia, October 25-27. The House of Delegates acts on the Society's 1986 dues after reviewing spending plans for the year.

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BOARD ADVISES ASSESSMENT TO FINANCE PR CAMPAIGN

The PMS Board voted September 18 to recommend a three-year assessment to finance a public relations campaign of the same duration. The recommendation for a $55 a year mandatory assessment each year for three years will be acted on by the House of Delegates at the 1985 Annual Business Meeting October 25-27, in Philadelphia. The PR campaign, devised by the Ad Hoc Committee on Public Relations, will consist of statewide television programming, radio spots, and newspaper and magazine advertising. Its major objective is public education. The cost of the first year of the program is estimated at $630,000.

MEDICAL PRACTICE ACT RE-ENACTMENT IMMINENT

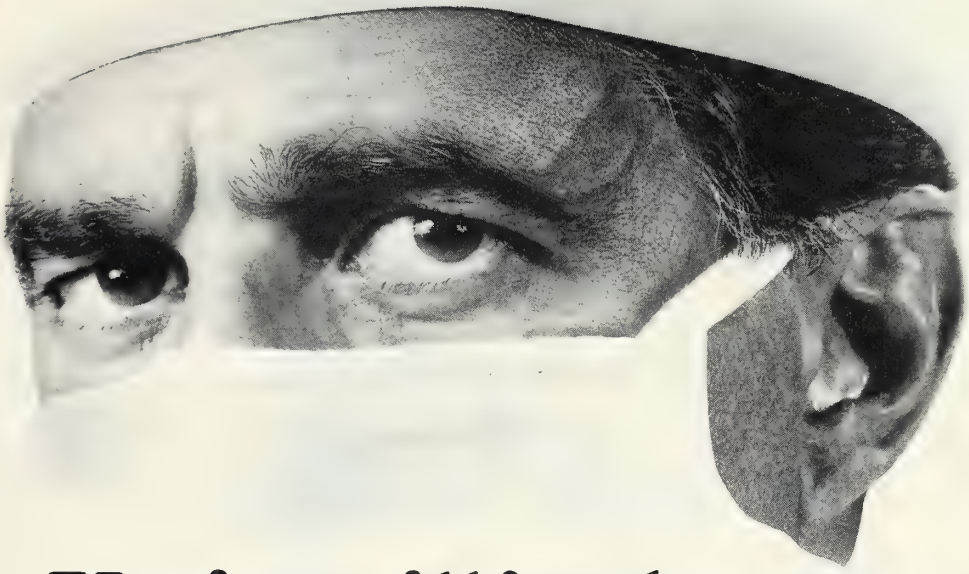
The Society's position on the re-enactment of the Medical Practice Act as required under Act 142 of 1981, the Sunset Review Act, was reaffirmed September 18 by the Board of Trustees. Over 75 state boards and agencies are being scrutinized this year under the sunset law. PMS has worked with the Senate Committee on Consumer Protection and Professional Licensure during the review process and on rewriting the Act, which will reauthorize the medical board and change its name to the "State Board of Medicine."

1986 SURCHARGE OF 87 PERCENT SET FOR CATASTROPHE LOSS FUND

Pennsylvania's Medical Professional Liability Catastrophe Loss (CAT) Fund filed its annual surcharge request with the Insurance Department on September 11. The Fund has requested a surcharge of 87 percent of the physician's basic insurance premium to cover liability claims in excess of the $200,000 basic limit. The 1985 surcharge is 70 percent. The CAT Fund will pay out almost $98 million in 1985. The 1986 filing, if approved, will generate $115 million.

AMA TELEVISES INAUGURAL MEDICAL STAFF CONFERENCE

The AMA's inaugural Medical Staff Conference will be televised nationwide from Washington, DC, by the Hospital Satellite Network (HSN) on October 18, from 1:00 to 5:30 p.m. eastern time. Convention style coverage of the two-day conference at the Sheraton Washington Hotel will feature the presentation of Margaret Heckler, secretary of the Department of Health and Human Services. The 23 hospitals which are members of the Pennsylvania Hospital Television Network will receive this programming as part of two days of special telecasts for physicians beginning at 6:00 a.m. on Thursday, October 17. Other hospitals with satellite receivers can collect the unscrambled signal for these two days only so that the widest possible audience can be reached. Access is through Spacenet I, Channel 11. Videotaping is permitted. Call HSN toll free for details at 1-800-638-3336.



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editorial

Relax, Type A—if you can

During the past two decades, it has become increasingly fashionable to expound upon the personality as an etiologic factor in disease onset and processes. Attempts to prove association of ulcers, ulcerative colitis, irritable bowel syndrome, coronary artery disease, myocardial infarction, asthma, and, perhaps, even cancer with certain personality types have produced masses of medical research and literature. Rosenman and Friedman first described the type A behavior pattern and its association with cardiovascular disease in 1959 in the *Journal of the American Medical Association.* Now, twenty-five plus years later, the purported effects of personality factors on disease are being scrutinized and, indeed, refuted by new studies. Case et al. reported in the *New England Journal of Medicine* on March 21, 1985 that in their studies no relation was found to exist between type A behavior and long-term outcome of myocardial infarction.

Ever since Biblical times, mankind has attached varying degrees of importance to personality as a causative factor in disease development or symptomatology. Many theories have evolved throughout the centuries, some religious in nature, some medical, and some just plain voodoo. Early American physicians interpreted disease symptoms by the four humors: blood, yellow bile, phlegm, and black bile. The patient's personality supposedly stemmed from one of the humors. Temperament, i.e. melancholy, sanguine, etc., controlled whether or not a patient contracted a disease and the severity of the symptoms. With better pathologic and physiologic understanding of disease processes, most physicians gradually abandoned the personality-causation theories in favor of more scientific explanations.

The interpretation of the diabetic personality as a cause of diabetes is a very good example of the evolution and later abandonment of such a theory. Thomas Willis' account of "The Diabetes or Pissing Evil," published in 1679, notes among the evident causes of diabetes, "(A)n ill manner of living, and chiefly an assiduous and immoderate drinking of Cider, Beer or sharp Wines; sometimes sadness, long grief, also convulsive affections, and other inordinations and depressions of the animal spirits . . ." Although several centuries elapsed between Willis' account and the publication in 1892 of Osler's "Principles and Practice of Medicine," Sir William wrote, "Persons of a neurotic temperament are often affected . . . Mental shock, severe nervous strain, and worry precede many cases." Today, it is difficult to find any reference at all to a diabetic personality and where mention is made, it is only to refute the concept on lack of evidence. When the cause of the disease is not clearly understood, it is comforting to cling to any plausible belief that accounts, more or less, for the evidence at hand.

If future research verifies the dissociation of type A personality and heart disease, this long held theory will find its way into volumes of medical curiosities and fads where many other once popular but now disproven theories are often relegated. Personalities have been linked with many ills but only a very foolish physician would attempt to predict the kind of disease or its onset from such inexact causes as repressed anger, depression or grief. Evidence in support of such beliefs has been shown to be largely anecdotal. Disease is a biological process, not a personal failure. J. Chalmers Da Costa noted, "A man who has a theory which he tries to fit to facts is like a drunkard who tries his key haphazard in door after door, hoping to find one it fits." But as long as disease remains a mystery, there will be the temptation to hypothesize to fit the known facts.

Bureaucrats and economists have fallen into this same trap.

David A. Smith, MD
Medical Editor

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Work with changes, new leader tells colleagues

Karen K. Davis

"One of my friends once remarked, 'you don't let any moss grow under your feet, do you, Alexander?' I said no."

This story is a self-description of the next president of PMS, R. William Alexander, MD. Board certified radiologist, delegate to the Pennsylvania Medical Society's House, delegate to the American Medical Association, past president of Berks County Medical Society, past chairman of a dozen medical committees on the state and county levels, his active career is proof of the story. He will be installed as the Society's 136th president at the Bellevue Stratford Hotel, Philadelphia, on October 26, 1985.

"I'm busy," he said. "People say they don't have time to do something. They just have to allocate their time. I say to them, 'don't tell me you don't have time; just tell me you don't want to allocate it that way. You have to decide whether you want to play golf, go fishing, take the kids out. There are so many things to do during a day and you have to decide what is most important and what you really want to do.' "

Participation important

One of the priorities for Dr. Alexander has been involvement in organized medicine. His interest goes back to his physician father. "He was an active member of PMS and a member of the delegation to the AMA, so I used to follow him to the meetings."

After medical school, training, and service in the Army, Dr. Alexander returned to Reading in 1955, and joined the county, state, and national medical societies. He served first on the county society's Council on Public Relations and then was named to the Committee on Public Relations of the state Society. "From there it took off!" he said. On the state level, he was appointed to the Public Service Council, and he became its chairman. In his county society, he was elected vice president in 1963, and then was installed as president in 1964. "One thing led to another and it was all very interesting," he said.

"I realized that one of the most active groups was the AMA—this is why I wanted to get involved with the AMA delegation. I compare the levels of organization of medical societies to the state legislature versus the national Congress—there is a difference in the magnitude and multiplicity of problems." The national scale was "very, very interesting to me," Dr. Alexander said, "so I stayed involved with that over the years." He was elected an alternate delegate to the AMA in 1969, became a delegate in 1975, and has served as chairman of the delegation since 1982.

Dr. Alexander went on to serve the State Society as a member of the Committee on Objectives, the Leadership Conference Committee, the PaMPAC Board, the Council on Government Relations, the Task Force to Study Professional Liability Insurance, and the Committee on Corporate Study. He has been the PMS representative to the state Health Care Policy Board, and the Society's representative to the Advisory Committee of the Health Policy Agenda for the American People.

He sees organized medicine as the way "physicians can work together as a group to accomplish better care." He said, "As far as I'm concerned, this is the most important reason for being involved." Physicians must join together "to work for the general betterment of the medical profession and better care of people."

Concerns for medicine

The current malpractice situation provides the biggest challenge to organized medicine, Dr. Alexander said. "We have to figure out how to take care of the patient, to be sure he is taken care of in justified suits without making the lawyers on the opposing sides the real winners. In a malpractice suit the offensive and defensive lawyers each get a third of the settlement, and the patient gets a third. How to turn that around—that is one of the biggest problems."

Other problems he sees are created by " 'the great thrust for cost effectiveness.' There are a lot of things a physician has no control over. How to get a better handle on the costs is difficult to work out," he said.

As an example, he pointed out that Philadelphia General Hospital, "the oldest medical care facility in the original colonies, has passed from existence due to the local city fathers deciding the cost of maintaining it could not be justified. If you take that one incident—the closing of a revered teaching facility by the local government based on the cost to operate that facility, you have a familiar example of the tremendous changes being wrought in the name of cost efficiency."

Alternative delivery systems are said to be cheaper methods for delivering health care—"we won't be paying the high prices for office visits and so forth," he continued. "That is fine until you come down to the last item, which is 'what quality of care is going to come out of this?' Nobody is against wonderful ideas unless they have bad results, and a potential bad result I can see is that patients are not going to get the same amount of care and the same quality of care.

"I was exposed to the people involved with the Kaiser-Permanente original HMO (health maintenance organization). When they were dealing with young individuals in wartime who had an accident or a single illness, got well, and never had a recurrence, cost factors for the plan were fine, but cost factors for HMO members in their 70s, 80s, and 90s are higher than for anyone else, and

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alog:Sci-Fi(13)	19.50	19.50	9.97	(10)
tique Monthly(18)	18.00	18.00	13.00	(12)
tNews(12)	25.95	25.95	21.95	
tist's Mag(12)	21.00	21.00	9.97	(9)
ts & Antiques(10)	36.00	29.95	29.95	
timov Sci-Fi(13)	19.50	19.50	9.97	(12)
tronomy(12)	21.00	21.00	15.75	(9)
tlantic Monthly(12)	9.95	9.95	9.95	
tenzione(11)	21.00	21.00	7.97	(8)
tlio(12)	17.94	17.94	8.97	
tdubon Magazine(6)	16.00	16.00	15.00	
to Racing Digest(6)	7.95	7.95	5.97	
tkpacker(6)	18.00	14.97	14.97	
tseball Digest(12)	14.95	14.95	7.97	(10)
tsketball Digest(8)	9.95	9.95	7.97	
tauty Digest(12)	15.00	15.00	15.00	
tter Health/Liv.(6)	15.00	15.00	11.97	
tetter Hms-Gdns(12)	12.97	6.49		
tycling(10)	15.97	8.00	11.97	
2 yrs(20)		15.97		
rd Watchers Dig(6)	11.00	11.00	11.00	
tck Enterprise(12)	15.00	9.00	7.50	
tating(12)	20.00	16.97	16.97	
t Appetit(12)	15.00	15.00	15.00	
tlling Digest(6)	12.00	12.00	9.97	
ts Life(12)	13.20	13.20	11.97	
tides(6)	12.00	9.00		
2 yrs(12)		16.00		
r & Driver(12)	17.00	11.99	11.99	
r Craft(12)	12.94	12.94	7.97	
ts (12)	17.50	17.50	12.50	
t Fancy(12)	17.97	17.97	12.97	
tnging Times(12)	15.00	9.97	9.97	
tld Life:age 6-10(8)	11.95	11.95	9.97	
tldrens Dig:7-11(8)	11.95	11.95	9.97	
tldrens Playmate(8)	11.95	11.95	9.97	
trcle Track(12)	19.95	11.95	11.95	
tnage(12)	14.00	14.00	11.95	
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tlumbia Journ.Rev(6)	16.00	16.00	9.95	
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#Science Digest(12)	13.97	6.99	13.97	
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Seventeen(12)	13.95	13.95	13.95	
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the original plan can't be used, it has to be changed," he said.

Dr. Alexander also is concerned about the future of medical education. "When you figure the cost of sending a student through undergraduate and graduate schools, and then residency training, average people can't do it. For the underpriveleged, it is totally out, and even people in the middle and higher middle income groups can't afford it. We're reaching the point where only those from a family that can afford it, can go [to medical school]. I'm not sure that's what we want to happen.

"Students come out now with debts of $120,000 to $160,000," he continued. "Then, if they want to practice a specialty, they might have a $50,000 or $100,000 malpractice premium before they even open up shop.

"No one can work his way through college any more. I was talking to a woman the other day who said she worked her way through college. I said, 'How did you do that?' She had a $100 scholarship per semester, and she worked over the summer for about $300 and that gave her the $500—enough to put her through each year of college. Now how did she get through medical school? Well, she took the summer off—she was a talented musician and played in a band and made $60 a night. So, she was able to put herself through medical school. Back then a lot of other people had part-time jobs in medical school—lab technicians and so forth—but when you are talking about $14,000 or $18,000 a year for medical school, nobody's going to make that much.

"Another one of my concerns is that over the course of the years medical education is always tapping the most brilliant student," Dr. Alexander said. The schools always accept "the straight 'A' student or the person who scored high on all the tests. No emphasis has been put on how to select a physician with the ability to deal with people, or on whether he or she will become an alcoholic or a drug user later because of pressure—there is no psychological testing. The students may be very brilliant and very academically oriented, but are they people oriented? They may be superb as far as diagnosis and treatment, but can they talk to people?

The coming year

In his remarks to the House of Delegates, Dr. Alexander plans to urge physicians to accept the changing environment. "If the transportation and banking communities have survived deregulation, and the steel and automobile industries have survived foreign competition, then we physicians must adjust to the multiple forces requiring new alignments in our referral patterns and fight the continuing battle with the third party payers," he said.

"We must reallocate our time to see that above all else, only quality medicine is made available to our patients. Today patients demand time for explanation of the problem; what can be done about it; what outcomes may be expected. At the same time, they demand the cutting edge of technology." Their demands, "require from us the most we can give," he said.

He also will advise the House to put the proposed public relations program into action: "If we don't tell the story about ourselves and our organization, there is no one else who will!"

He said there are two objectives to the public awareness program: "first, to

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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

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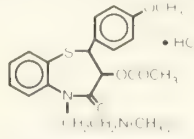
PROFESSIONAL USE INFORMATION

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

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The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

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In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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position PMS and its members as advocates of the consumer on health care issues, and second, to act as a unified statewide force to advance the interests of all physicians." This would "enhance the Society's value to current members and increase its attractiveness to nonmembers," he added. "The strategy includes designing the program to show that physicians do care about people, and positioning PMS as a reliable source on controversial aspects of health care."

Besides working as a group, doctors must work individually to make the public's perception of medicine a positive one, Dr. Alexander said. "We must learn to give more time for personal contact and discussion with each patient so that we will become more trusted, more accepted, more human. This will mean changing thought processes to project to the other side of the two-way conversation between doctor and patient. Tell your patient what you would want to hear, what you would like to know, and if you have satisfied your own wishes, you can be assured that you are practicing quality medicine and communicating well with your patients," he said.

Education and training

After graduating from high school in Reading in 1942, Dr. Alexander went on to Swarthmore College. Since the war effort at that time produced a great demand, students "had to decide after two years of college whether they wanted to go to medical school, and at the end of three years they had to go," he said. So, after three years at Swarthmore, he went on to Jefferson Medical College, his father's alma mater.

His father, an internist, "never pushed me into medicine—that was entirely up to me," he said, "but other vocations never fascinated me."

He graduated from Jefferson in 1948, and went on to an internship and residency in radiology at Philadelphia General Hospital. He chose radiology because he felt "it wrapped up everything. Radiology sees the anatomy and the pathology and the physiology, and at that time it was one of the more effective ways of treating cancer."

At the end of residency training, "I got hauled into the Army and went overseas, headed to Korea. At Camp Drake in the Tokyo area, they were calling the names of everybody going to Korea. I was standing there with my rifle and my pack, ready to get on the boat; I was all set to go." But instead of Korea, he was assigned to Tokyo Army Hospital. "I was third in command. There was a full colonel, a lieutenant colonel, and a silver-barred lieutenant—that was me. I stayed there for two years; both colonels left, and I ended up as director of the department of radiology at Tokyo Army Hospital.

"We had a tremendous volume there," he said. All the patients were evacuated from Korea. We would get 150 to 175 patients a day; we had almost 1,500 beds."

Return to Reading

Discharged from the Army in 1954, Dr. Alexander went temporarily to San Antonio, Texas, to cover for a friend in a group practice. The next year he came home to Reading and opened his radiology practice at 544 Elm Street. Currently he also serves as chief of radiology at Hamburg Center and Hospital and Hamburg Family Practice Center, radiology consultant at Lebanon Veterans Hospital, and radiology clinician at the Pennsylvania Department of Health Chest Clinic in Reading.

When asked what professional achievements he was proudest of, Dr. Alexander said becoming president of PMS was one, and he listed his election to fellowship in the American College of Radiology as another. Dr. Alexander is a member of the Pennsylvania Radiological Society, the Philadelphia Roentgen Ray Society, the North American Radiologic Society, and the Blockley Radiology Society.

Along with his participation in medical activities, Dr. Alexander participates in community affairs. He is past president of the Kiwanis Club of Reading, and is a board member of the Chamber of Commerce of Berks County, as well as the county's United Way, Red Cross, and Lung Association chapters. He currently serves as president of the Berks Visiting Nurse-Home Health Agency, and he has been on the board of directors for that organization since 1959.

Outside medicine, Dr. Alexander said he enjoys golf, photography, and gardening. He and his wife Nancy have two children—a daughter, Heather, who is a sophomore at Franklin and Marshal College, Lancaster; and a son, William, who this year entered West Virginia University.

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Workshop Fee: $295/participant for the presentations, lunch, refreshments, and literature package.

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ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) LONG ACTING CAPSULES

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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C: INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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J-5491 June 1985

Health department reports 1984 disease statistics

The Pennsylvania Department of Health recently released its 1984 statistics on diseases that are required to be reported to the state. Cases were reported to the health department from a variety of sources, including hospitals, doctors' offices, nursing homes, and schools. The information is presented in tables with monthly totals for diseases; patients are grouped by county and by age. Below are summaries of statistical information for some of the diseases listed in the health department's report:

AIDS—Cases continued to increase in 1984. Since the state began its AIDS surveillance program in 1981, cases have increased approximately three times each year. There were three cases of AIDS in 1981; 16 in 1982; 46 in 1983; and 123 last year. Through the end of last year, homosexual and bisexual males accounted for 82.1% of the cases. The remaining cases included intravenous drug users—7.9%; hemophiliacs—2.5%; blood transfusions—1.7%; heterosexual contact—0.4%; and unknown or no apparent contact—3.3%.

Primary encephalitis—Reported cases decreased to 56. There were 77 cases reported in Pennsylvania in 1983.

Giardiasis—Cases rose from 500 in 1983 to 1,968 last year. Outbreaks associated with municipal water supplies were reported from Allegheny, Clearfield, Lackawanna, and Luzerne Counties. Here is a two-year comparison of the cases reported from those four counties:

County	1983	1984
Allegheny	28	456
Clearfield	5	52
Lackawanna	18	124
Luzerne	17	314
Totals:	68	946

Hepatitis—Reported cases decreased last year. Type A Hepatitis (usually associated with contaminated food) dropped from 851 cases in 1983 to 620 cases in 1984. Cases of Type B Hepatitis (often associated with the use of dirty needles or syringes) decreased from 1187 in 1983 to 1088 last year.

Legionnaires' Disease—Reported cases last year totaled 68. There were 75 cases in 1983. Allegheny County reported 18 cases, or 26 percent of the state total last year. Twenty of Pennsylvania's 67 counties reported at least one case. Cases occurred in all months with a peak of 17 cases (25 percent of the total) in August.

Malaria—Cases increased from 24 in 1983 to 36 last year. All cases were acquired outside the United States and brought back to Pennsylvania. Malaria in foreign civilians accounted for 28 (78 percent) of the 36 reported cases.

Rabies (animal)—Rabies continued at epidemic levels in wildlife. The 384 cases last year were the most in Pennsylvania since 1946. Raccoons were the species most commonly affected with 281 cases reported (73 percent of the total). Although 37 counties reported at least one case of rabies, the southcentral counties of Franklin (106 cases), Adams (85 cases), Cumberland (58 cases), Huntingdon (22 cases), and Bedford (21 cases) reported 76.6 percent of the state's total cases.

Rabies (human)—The first human rabies death in Pennsylvania since 1952 occurred last September. It involved a 12-year-old male from the Williamsport area of Lycoming County. The investigation did not reveal a source of exposure although a strain of rabies virus commonly found in bats was isolated and identified by the state health department's laboratory.

Rocky Mountain Spotted Fever—Twelve cases were reported last year, compared to 13 cases in 1983. All of last year's cases had onsets between May and September. Tick exposure was confirmed in all but one case. All cases occurred in the eastern half of the state, with eight of the 12 occurring in southeastern Pennsylvania.

Salmonellosis—Cases rose to 2,073 last year compared to 1,904 in 1983. Approximately 50 percent of the 1984 cases were reported from four counties: Philadelphia (541), Allegheny (241), Montgomery (188) and Lancaster (103). Forty-five percent of the cases occurred in two age groups: three years of age and younger (515 cases) and 60 years and older (428 cases). June was the peak month with 264 cases.

Toxic Shock Syndrome—Cases decreased from 29 in 1983 to 14 last year. Ten of the 14 cases (71 percent) last year were associated with tampon use. Two cases were associated with wound infections. One case occurred following a Caesarian section and one case was associated with the contraceptive use of a diaphragm.

Trichinosis—Four cases were reported last year. All four involved adults (25-41 years of age). Two consumed pork from the same hog from which Trichina larvae were isolated through laboratory testing. The source of the two others was not determined although they reported occasional raw pork consumption.

Typhoid Fever—Ten cases were reported last year, eight in 1983. Nine of the 10 cases reported in 1984 were exposed during foreign travel to India, Mexico, Peru, or Chile. One case occurred following contact to a carrier of the disease. All cases recovered completely.

For a copy of the complete report, write the Pennsylvania Department of Health, Division of Epidemiology, Room 1014, Health and Welfare Building, Harrisburg 17108.

Dr. Graham gets top post

William P. Graham, MD, clinical professor of surgery at Pennsylvania State University College of Medicine, Hershey, has been elected chairman of the American Board of Plastic Surgery.

Dr. Graham is a graduate of Princeton University and the University of Pennsylvania School of Medicine. He has served as secretary-treasurer of the American Board of Plastic Surgery for the past three years.

Physicians must check MA eligibility cards

The Department of Public Welfare (DPW) has changed Medical Services Eligibility (MSE) cards for Medicaid patients. In August, DPW combined the cash assistance and Medical Assistance files into one file to improve the administration of the programs.

Expiration dates on the new cards will not be limited to the last day of the month. They will expire throughout the month. It will, therefore, be necessary to check the expiration date each time services are provided. As the new cards are issued, many case numbers will change, making it necessary to check the MA identification number also.

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DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) for Anxiety (lorazepam)

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

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*Benzodiazepines have not been shown to be of benefit in treating the cardiovascular component.

See important information on preceding page.

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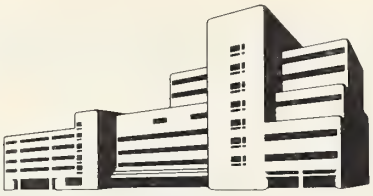

Wills Eye Hospital

Continuing Medical Education Seminars

1985

Ophthalmology for the Family Medicine/General Practice Physician *October 9*

Ophthalmology Update for School Nurses and Pediatric Nurses (PNA) *October 18*

Neuro-Ocular Manifestations of Cervical Vascular Disease *October 19*

Eyelid Update: Practical Management of Eyelid Disorders *October 26*

Vitrectomy Techniques for the General Ophthalmologist *November 2–3*

The Tenth Annual Contact Lens Conference *November 8–9*

The Sixth Biennial Cornea Meeting *November 22–23*

Retina Update: "Retina & Systemic Diseases" *December 7*

1986

Pediatric Ophthalmology for the Pediatrician *January 11*

Oncology Update: "Orbital and Adnexal Tumors" *January 18*

Retina Update: "Fundus Diagnosis" *February 1*

Oncology Update: "Intraocular Tumors" *February 15*

Ultrasound Workshop: A & B Scan *February 22–23*

Retina Update: "Trauma & Infections of the Retina" *March 1*

The Eleventh Annual Ophthalmology Review Course *March 8–12*

The 38th Wills Eye Hospital Annual Conference *March 13–15*

Small Incision IOL Course *April 5–6*

Vitrectomy Techniques for the General Ophthalmologist *April 12–13*

Lasers in Ophthalmology: Principles and Practices *May 3*

Glaucoma Conference *June 13–14*

Allied Health Personnel Workshops

Seminars for Ophthalmic Assistants are offered throughout the year. Contact the Department of CME for further information.

Peter J. Savino, M.D., Director
Department of Continuing Medical Education

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Further Information:
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Department of Continuing Medical Education
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Philadelphia, PA 19107

Ms. Lucia M. Manes, Conference Coordinator
215-928-3378

East German physician visits Pennsylvania

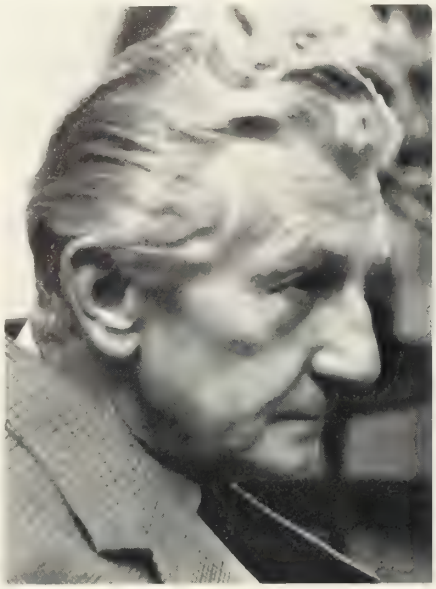
Karen K. Davis

Dr. Johannes K. Gaertner, an East German physician who spent his career proving family practice is a valid specialty, this summer visited the United States as the guest of Society member Hiram L. Wiest, MD, of Hershey. Dr. Gaertner and his wife were guests of the Wiests in May and June.

Dr. Gaertner and Dr. Wiest have enjoyed a friendship which grew out of their mutual interest in the specialty of family practice. Dr. Gaertner, now a pensioner living in the village of Hainewalde, worked to establish family practice as a recognized specialty in East Germany. Dr. Wiest, who retired in 1981, was director of predoctoral education and associate professor of family medicine at Pennsylvania State University College of Medicine, Hershey.

Dr. Wiest first met Dr. Gaertner in East Germany while there observing the teaching and practice of family medicine in order to improve the program at Hershey.

Five years later, while Dr. Wiest was on sabbatical, serving as a licensed general practitioner at the clinical unit of the University of Manchester, England, there was a conference in Dresden of the International Society of General Medicine, a group Dr. Gaertner founded. At the conference, the two doctors met for the second time, and Dr. Wiest and his wife were guests in the



Gaertner's home. Since then, the two families have kept in touch. "We manage to get a letter to each other a couple times a year," said Dr. Wiest, adding that his children also correspond with Dr. Gaertner's sons.

Dr. Gaertner was born in Hornhausen, Germany in 1915. After finishing high school, he studied to enter the medical profession at Konigsberg, and then at Tubingen and Berlin, where he passed the government examination and received his medical degree in 1941. "After some months experience as an assistant, I was called to duty for the German army," Dr. Gaertner said.

He became a medical officer in the army during World War II, going first to France and later to the Eastern Theater of the war near Stalingrad. "There," Dr. Gaertner said, "I fell ill. This was to my good fortune, because I came out from that place." He spent the next two years working in an army hospital.

He became interested in the scientific theory of general practice, because "at this time general practice physicians were not trained and they did not serve in the army." With several other physicians, he began to make plans for practical courses in hospitals to teach the specific sciences needed for general practice. He also began to write papers on the importance of general practice.

He gained his first experience as a "countryside doctor" (general practitioner) in Bautzen, where he set up a practice for a year after the war. Next, he moved to Hainewalde, his present home, in the southeast part of the country near the Czechoslovakian border. "I spent ten years as a countryside doctor in the village of Hainewalde, from 1948 to 1959," he said. "At this time, the government took the first steps to have a national health service."

When the national health service was being established, the government questioned whether general practice should be the base of primary care, Dr. Gaertner said. "They wanted to introduce a system of health care with specialists in internal medicine. Some of my friends and I did not believe this idea would cover the needs of the people and we felt that there was a scientific basis for general practice.

"During this period we had an interesting experience with friends from Austria and West Germany," Dr. Gaertner said. "We exchanged information, and found scientific statements are true (regardless of location or society). This brought us the idea to form our International Society of General Medicine (SIMG). It consisted of doctors from the GDR (German Democratic Republic), Austria, and West Germany." Dr. Gaertner was one of the three original

Eastern Pennsylvania has new hospital care system

Presidents of eight nonprofit hospitals met in July to establish VHA East, a voluntary regional partnership for health care. It is the largest such regional health care system in eastern Pennsylvania.

The partnership, which will operate under the auspices of Voluntary Hospitals of America (VHA), includes Chester County Hospital, Chestnut Hill Hospital, Crozer-Chester Medical Center; Episcopal Hospital; Frankford Health Care System; Jeanes Health System; Health East, Inc. (which is comprised of Allentown Hospital, Lehigh Valley Hospital Center in Allentown, and Slate Belt Medical Center in Bangor); and Pennsylvania Hospital. Through the VHA partnership, each hospital will have the advantages of operating within a multi-hospital system. By utilizing partner institutions and affiliated physicians, VHA East expands resources and capabilities enabling these institutions to compete collectively in delivering health care.

VHA was founded in 1977. Today it is one of the largest multi-hospital systems in the country, with regional partnerships in over 35 states. VHA East will adopt VHA's corporate goal of encouraging each hospital to develop programs and services geared toward collectively providing quality health care while still maintaining individual autonomy and community identity.

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For more information, call Ms. Gail Wallis, (215) 456-7023.

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In a visit to the Society's headquarters Drs. Gaertner, center, and Wiest, right, talk with LeRoy Erickson, executive director of the Educational and Scientific Trust.

founders of the society, which was set up in September 1959, in Vienna, Austria. He gave the opening address at the organization's first meeting and served on the board for ten years.

During the 1960s, his own country recognized the field of general medicine and established the official title of "specialist in general practice." Dr. Gaertner and his colleagues founded the Society of General Practice of the GDR, and they also worked on a new training program, which was adopted in 1967, requiring family practitioners to take five years of postgraduate education. In East Germany today, only physicians who have completed this five year residency program may practice general medicine. "They are the specialists acknowledged for primary care; the others are not," Dr. Gaertner explained.

Throughout his career, Dr. Gaertner has worked to develop the scientific theory on which general medicine is based. He has published over 60 papers on the theoretical aspects of family medicine. In 1976, he was awarded the Hippocrates Medal of the International Society of General Medicine. He was elected honorary member of the Hungarian Society of General Practice, and corresponding member of the West German Society of General Practice. From 1970 to 1975, he was professor of ergonomics at Zittau Technical University.

Dr. Gaertner's trip to the United States included visits to several health care facilities including Hershey Medical Center; St. Joseph Hospital, Reading; Harrisburg Hospital and Polyclinic Medical Center, Harrisburg; and Lancaster General Hospital. He also attended a residents' conference at the University of South Carolina School of Medicine, where Dr. Wiest's son, Samuel, is training in family practice.

Dr. Gaertner also visited the Eastbrook Family Health Center, Lancaster County, and the solo family practices of Milton S. Good, MD, Elizabethtown, and Thomas W. O'Connor, MD, Mt. Joy. "The patients I saw here and their diseases are very similar to ours," Dr. Gaertner said. "From what I've seen, American practice may have a little higher level of technology. But that is not the only way to give good care to people," he added.

"In all places, in my country and here, the theory of human beings is not on the same level of development as the technology," he said. Physicians must deal with "patients who have pain without organic cause or base; and the problem is that the medical sciences have not yet researched all the problems in the human beings' living process—perhaps only 50 percent."

In his current practice, Dr. Gaertner deals with problem patients; those with complaints that couldn't be solved by doctors in the public health system. Although the main system of medicine is socialized, doctors in East Germany are allowed to establish private practices.

There is no liability insurance crisis in East Germany, according to Dr. Gaertner. "All the doctors employed by the government also have government insurance to save them from the results of malpractice." Doctors who have private practices must buy extra insurance coverage. "For me," Dr. Gaertner said, "it costs 60 Marks (about $20) a year.

"It's not very often that patients accuse a doctor of malpractice," he said. "If there is such a case, it is investigated by the state justice bureau. Then they decide what is right and what is not. It is not possible to get a high rate of income from such a case, because the patient gets from the bureau only what he has lost in terms of work or income.

"Each country can learn a lot of things from the other, because of special experiences, even though the patients in both countries may be nearly the same," Dr. Gaertner said. "There are a lot of advantages and disadvantages in both countries, and we are accustomed to dealing with our disadvantages just as you are accustomed to dealing with your disadvantages."

International expert speaks on terrorism

A world renowned authority on emergency medical response to terroristic activities has accepted an invitation to speak from the Pennsylvania Division of The American Trauma Society. He will speak at a dinner at the Embers Convention Center, 1700 Harrisburg Pike, Carlisle, Pennsylvania, on Friday, November 15, 1985.

Dr. William Rutherford, a surgeon and consultant in accident and emergency medicine in Belfast, Ireland, has chosen as his topic "Is Terrorism Inevitable In the Late 20th Century?"

A social hour from 6 to 7 p.m. will feature "mockaholic" drinks prepared by the staff at the Embers to resemble mixed drinks but without alcohol. Dinner will be followed by the speaker and music for dancing by the Dr. Frank Bryan trio. The price is $25 per person.

The dinner-dance is open to all interested persons. Tickets may be obtained from Cindy Sniscak, ATS Project Coordinator at 763-7053, Ext. 160; Carol Forrester, executive director of the Pennsylvania Trauma Systems Foundation at 763-7053, Ext. 172; or Julia Cox, executive assistant to the Secretary of Health at 787-6436.

Overnight accommodations can be made directly by contacting The Embers Convention Center, 1700 Carlisle Pike, Carlisle, PA 17013.

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Guest Speakers: Gifford V. Eckhout, M.D.
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Cytotoxic test for allergies banned in state

Josephine Bartola, JD

In October 1983, the Bureau of Laboratories received inquiries from two out-of-state laboratories as to whether cytotoxic testing for food sensitivities was subject to the Pennsylvania Clinical Laboratory Act. As represented, both laboratories indicated that the results of the tests were used for nutritional counseling only and that health problems were not addressed.

These laboratories were advised at that time that as represented, cytotoxic testing did not appear to come within the definition of the Act. These laboratories were also advised that the bureau would continue to monitor the use of the test. Should it be determined that the test was used to determine a state of health, it would be necessary to re-evaluate this decision.

In June 1984, the bureau became aware of advertisements in the Philadelphia newspapers and elsewhere promoting cytotoxic testing in this state. These advertisements claim that for a small blood sample, consumers with any of a long list of medical problems could learn what foods to avoid to cure or alleviate these ailments. These claims clearly offer the test to determine a state of health, contrary to previous representations made. Physicians are solicited by these laboratories to order the test for their patients and, in fact, some physicians are using the results for diagnosis and treatment purposes. Accordingly, laboratories conducting the cytotoxic test come within the definition of a clinical laboratory subject to the Clinical Laboratory Act.

However, no license will be issued to any laboratory to perform cytotoxic testing because after extensive investigation, the Department of Health has determined that the cytotoxic test is not an accepted procedure. It is an unproven diagnostic test lacking an acceptable scientific rationale, specificity, sensitivity, and evidence of clinical effectiveness. The test is not supported by the scientific literature or well-controlled studies and clinical trials according to Food and Drug Administration Guide No. 7124.27.

In addition, the FDA Guide states that the only lawful, commercially marketed allergenic extracts are those licensed by the FDA and none have been approved for cytotoxic testing. It should be noted that allergenic extracts compounded within a laboratory itself as well as commercially marketed allergenic extracts are subject to the Pennsylvania Controlled Substances, Drug, Device and Cosmetic Act. Accordingly, this matter has been referred to the Department of Health, Division of Drugs, Devices and Cosmetics for possible action.

In view of the above, effective *immediately,* all facilities must cease and desist from offering and conducting the cytotoxic test for food allergies until the test can be validated. Cytotoxic testing poses a dangerous threat to the health and safety of individuals, especially those with serious health problems who may postpone seeking proper medical attention based upon the unsubstantiated claims made for cytotoxic testing.

Any laboratory presently licensed under the Clinical Laboratory Act to perform categories of tests currently acceptable to the Department of Health will lose its permit if the laboratory performs cytotoxic testing. Unlicensed facilities that continue to perform cytotoxic testing will be subject to legal action and the penalties under the Clinical Laboratory Act.

The author is director of the Division of Laboratory Improvement of the Bureau of Laboratories, Pennsylvania Department of Health.

Physician writes book on pneumonia

Robert Austrian, MD, a Philadelphia scientist who helped develop the pneumonia vaccine in the 1960s, has written *Life with Pneumococcus: Notes from the Bedside, Laboratory, and Library,* his own personal account of the disease, and the trials and errors and ultimate success with the vaccine. The book recently was published by the University of Pennsylvania Press and sells for $25.

Dr. Austrian is John Herr Musser Professor and chairman of the department of research medicine at the University of Pennsylvania School of Medicine. At the university, he also directs the World Health Organization's Collaborating Centre for Reference and Research on Pneumococci.

Society-sponsored workshops offered

Society-endorsed workshops on establishing a successful medical practice, how to be a better receptionist, and insurance management and collection procedures are currently being offered by Practice Productivity, Inc.

Half-day seminars on how to be a better receptionist include topics such as handling patients, telephone skills, and the role of the receptionist.

The half-day workshop titled Insurance Management and Collection Procedures will include discussion on establishing an office routine, improving office insurance systems, handling unique collection problems, and using effective follow-up techniques.

More information and registration materials can be obtained by calling Practice Productivity's toll-free number, 1-800-241-6228.

Dates and locations for the receptionist and insurance collection workshops are as follows:

October 22	Wilkes-Barre
October 23	Allentown
October 24	King of Prussia
October 29	Johnstown
October 30	Pittsburgh
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HYDERGINE® LC
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liquid capsules, 1 mg

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HYD-1085-13

For Brief Summary, please see following page.

HYDERGINE® LC

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Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see Contraindications).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternative treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, recent memory, orientation, emotional lability, self-care, depression, anxiety/fears, cooperation, sociability, appetite, dizziness, fatigue, bothersome(ness), and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

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Also available: HYDERGINE sublingual tablets; 1 mg, oval, white, embossed "HYDERGINE" on one side, "78-77" other side. Packages of 100 and 1000. 0.5 mg, round, white, embossed "HYDERGINE 0.5" on one side, "S" other side. Packages of 100 and 1000.

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obituaries

• *Denotes PMS membership at death.*

• **Arthur G. Baker,** Folsom; George Washington University School of Medicine, 1932; age 80, died June 22, 1985. Dr. Baker practiced general medicine and served as head of the department of medicine at Taylor Hospital, Ridley Park.

• **Howard Walter Baker,** Pinehurst, North Carolina; Temple University School of Medicine, 1938; age 73, died June 3, 1985. Dr. Baker was former vice president of Greater Philadelphia Blue Cross and Blue Shield, and he held administrative posts at Temple University Hospital.

• **Velio E. Berardis,** Scranton; Jefferson Medical College of Thomas Jefferson University, 1948; age 62, died June 17, 1985. Dr. Berardis practiced family medicine in Scranton for over 30 years.

• **Charles P. Bowen,** Pittsburgh; University of Pittsburgh School of Medicine, 1953; age 60, died July 28, 1985. Dr. Bowen was an obstetrician.

• **Edward C. Britt,** Belmont, Massachusetts; Jefferson Medical College of Thomas Jefferson University, 1933; age 77, died July 4, 1985. Dr. Britt maintained a family practice in Philadelphia until his retirement.

• **Alfred W. Brunacci,** Laflin; Georgetown University School of Medicine, 1934; age 82, died July 22, 1985. Dr. Brunacci specialized in orthopedic surgery.

• **Guy C. Crist,** Harrisburg; Jefferson Medical College of Thomas Jefferson University, 1922; age 86, died July 24, 1985. Dr. Crist specialized in proctology.

• **Robert Jay Doman,** Redlands, California; Hahnemann University School of Medicine, 1946; age 63, died July 29, 1985. A specialist in rehabilitation medicine, Dr. Doman headed one of the nation's first successful stroke rehabilitation programs, founded in 1960 by the state health department. He was a former resident of Media.

• **Edwin O. Geckeler,** Wynnewood; Hahnemann University School of Medicine, 1922; age 87, died June 10, 1985. Dr. Geckeler was former professor and chief of orthopedic surgery at Hahnemann University Hospital.

• **Joseph F. Greco,** Mount Carmel; Hahnemann University School of Medicine, 1945; age 66, died June 6, 1985. Dr. Greco served on the staff of Shamokin State General Hospital for 40 years.

• **Vincent B. Hall,** Murrysville; University of Pittsburgh School of Medicine, 1943; age 65, died July 31, 1985. Dr. Hall was a family physician in Murrysville for 41 years.

• **William Y. Inouye,** Elkins Park; University of Pennsylvania School of Medicine, 1953; age 65, died July 20, 1985. Dr. Inouye was emeritus professor of surgery at the University of Pennsylvania.

• **Merwin R. Jackson,** Kennett Square; University of Pennsylvania School of Medicine, 1943; age 67, died July 1, 1985. Dr. Jackson was a general practitioner.

• **Clark F. Kopycinski,** Erie; Hahnemann University School of Medicine, 1971; age 39, died July 27, 1985. Dr. Kopycinski was a family practitioner.

• **Charles L. Leedham,** Harrisburg; University of Iowa College of Medicine, 1928; age 81, died June 13, 1985. Dr. Leedham, a retired Army colonel and retired director of Educational Activities of the state health department, was former chief of Medical Services of the U.S. Forces Far East Command, and personal physician to General John J. Pershing.

• **Perry Cyrus Martineau,** Upper St. Clair; University of Michigan Medical School, 1943; age 67, died June 26, 1985. Dr. Martineau, a pathologist, served as director of laboratories at McKeesport Hospital.

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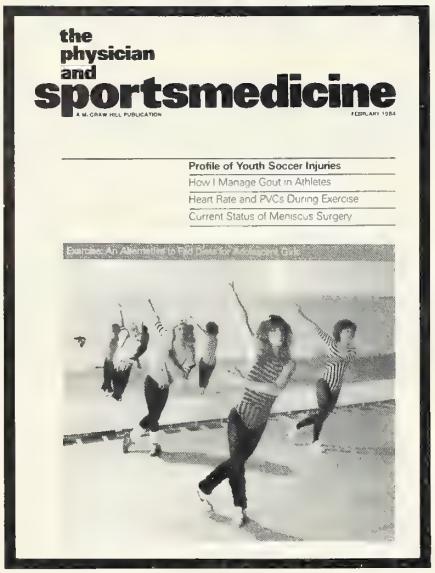

Practical information on the medical aspects of fitness and exercise.

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• **Carroll R. McClure,** Orange City, Florida; Hahnemann University School of Medicine, 1927; age 82, died June 21, 1985. Dr. McClure practiced medicine in Chester County before his retirement.

• **Henry N. Miller,** Reading; New York University School of Medicine, 1937; age 73, died August 6, 1985. Dr. Miller was an internist and maintained a practice in Reading for over 40 years.

• **Richard S. Oakey Jr.,** Rose Valley; Hahnemann University School of Medicine, 1945; age 69, died July 12, 1985. Dr. Oakey was a plastic surgeon.

• **Richard J. Peters,** Greenville; State University of New York Upstate Medical Center College of Medicine, 1952; age 57, died July 3, 1985. Dr. Peters was an internist.

• **Jordan C. Pratt,** York; University of Maryland School of Medicine, 1962; age 49, died July 3, 1985. Dr. Pratt was an ophthalmologist.

• **Jack Zeth Rohm,** Carnegie; University of Maryland School of Medicine, 1932; age 70, died July 14, 1985. Dr. Rohm specialized in otolaryngology.

• **Walter B. Watkin,** Saltillo; Jefferson Medical College of Thomas Jefferson University, 1938; age 71, died June 16, 1985. Dr. Watkin specialized in emergency medicine.

• **Harold P. Weaver,** Allentown; University of Pennsylvania School of Medicine, 1943; age 66, died June 30, 1985. Dr. Weaver was a surgeon.

James Stanley Anderson, Plum; University of Pittsburgh School of Medicine, 1921; age 87, died July 2, 1985. Dr. Anderson was a physician at the former Columbia Hospital in Wilkinsburg before it became part of Forbes Health Center.

Arthur W. Drieling, Greenock Heights; University of Pennsylvania School of Medicine, 1923; age 89, died June 16, 1985. Dr. Drieling practiced medicine in McKeesport and Pittsburgh.

Mark H. Gilliand, Pittsburgh; University of Pittsburgh School of Medicine, 1981; age 29, died June 15, 1985. Dr. Gilliand was in his fourth year of an anesthesiology residency at University Health Center, Pittsburgh.

Thomas M. Hadden, Saltsburg; Temple University School of Medicine, 1933; age 77, died July 9, 1985. Dr. Hadden practiced medicine in the Saltsburg area for 48 years.

James T. Hansberry, Lancaster; University of Pittsburgh School of Medicine, 1951; age 67. Dr. Hansberry was former head of the family practice department at St. Joseph Hospital, Lancaster.

Michael J. Herbert, Minersville; Temple University School of Medicine, 1934; died June 17, 1985. Dr. Herbert was a general practitioner.

John R. Herr, New Oxford; Temple University School of Medicine, 1940; age 79, died July 13, 1985. Dr. Herr was a general practitioner and obstetrician.

Samuel S. Leiter, Philadelphia; University of Pennsylvania School of Medicine, 1943; age 73, died June 27, 1985. Dr. Leiter specialized in family medicine.

John J. McCarthy Sr., Pittsburgh; University of Pittsburgh School of Medicine, 1922; age 90, died May 25, 1985. Dr. McCarthy formerly served on the staff of Mercy Hospital, Pittsburgh.

Helen E. McGovern, Wilkes-Barre; Loyola University of Chicago Stritch School of Medicine, 1929; age 82. Dr. McGovern was a general practitioner.

Frank R. Notz, Scranton; Georgetown University School of Medicine, 1934; age 77, died May 15, 1985. Dr. Notz was former chief of the anesthesiology department of Mercy Hospital, Scranton.

George E. Peatick Sr., Indiana; Hahnemann University School of Medicine, 1926; age 88, died June 12, 1985. Dr. Peatick specialized in psychiatry.

capital commentary

Health agenda keeps legislators busy

Robert H. Craig Jr.
Jerry L. Rothenberger
Larry L. Light

The State House of Representatives and State Senate reconvened in Harrisburg in mid-September for the fall legislative session. Here is an update on legislative issues that have been followed closely by the PMS Council on Legislation, and with which the Society's staff lobbyists have been involved on a daily basis during this session of the General Assembly.

Sunset of the State Board of Medical Education and Licensure—The Senate Consumer Protection and Professional Licensure Committee is scheduled to act on the sunset and renewal of the state medical board by October with a comprehensive reform bill. The Society is seeking to strengthen the board, toughen its disciplinary powers, and update its licensure authority.

Cost containment—To date, 11 bills have been introduced in the House of Representatives and the Society has testified at public hearings held by the House Health and Welfare Committee on the following issues: uncompensated care, data collection, utilization review, and capital cost controls.

Living will (HB-1487)—A procedure by which a person can provide in advance for the withholding or withdrawal of medical care in the event the person should suffer a terminal illness or a mortal injury is provided. The bill is in the House Health and Welfare Committee.

Anatomical gifts—There are seven bills introduced which seek to preserve immunity for coroners, deputy coroners, medical examiners, and eye banks for removing donors' eyes or which specify that consent from next of kin is not necessary when a valid donor's card is available.

Organ transplants (SB-276)—The bill would create Pennsylvania Organ Transplant Procedure Board to determine the eligibility and payment of Department of Health funds to transplant recipients. It is in the Senate Public Health and Welfare Committee.

Acupuncture (SB-693)—The Acupuncture Registration Act, was reported from committee with clarifying amendments sought by the Society and is now in the Senate Appropriations Committee.

Smoking in public places (HB-259)—The Society testified at public hearings on this bill which is still in the House Health and Welfare Committee. The bill would establish smoking zones in public places, including restaurants.

Smokeless tobacco (HB-1168)—This bill requires that a warning of cancer hazards be printed on smokeless tobacco products. Public hearings are scheduled for late summer and fall by the House Business and Commerce Committee.

Safety belts—Public hearings have been held by the Senate Transportation Committee. To date there are seven bills introduced which would require the use of safety belts by all passengers in a car or by front seat passengers. There are several variations regarding provisions that U.S. Secretary of Transportation Dole has proposed.

Hemodialysis (SB-238, SB-275, HB-346)—All three bills require that the Department of Health regulate the reprocessing and reuse of disposal hemodialysis filters. All bills are still in the original committee to which they were referred in the House or Senate.

Low level radioactive wastes (SB-417)—This bill would place Pennsylvania in compliance with the Regional Appalachian State Low Level Radioactive Waste Compact. It has passed the Senate (46-2) and is now in the House Conservation Committee.

Immunity defense (SB-332)—This bill would assure health care providers of reimbursement for legal defense costs when they are sued for reporting patient information required by law. It has passed the Senate (47-0) and is now in the House Judiciary Committee. An identical bill, HB-1421, is in the House Health and Welfare Committee.

Insurance: Nurses (HB-607)—This bill mandating direct payment for health services provided by nurses is in the House Insurance Committee. Committee action is scheduled for September.

Insurance: Psychologists (SB-598)—This bill mandating health insurance companies to pay for the services of psychologists remains in the Senate Banking and Insurance Committee.

Cancer treatment (SB-679)—This bill requires health insurance companies to pay for all cancer chemotherapy and cancer hormone treatment. It is in the Senate Banking and Insurance Committee.

Physician assistants (HB-770, HB-771)—These are amendments to the medical practice (HB-771) and osteopathic (HB-770) acts. The acts now *require* the pharmacy board to develop joint regulations with the separate physician boards permitting a physician assistant to prescribe and dispense drugs at the direction of a physician. The amendments would permit physician assistants to prescribe and dispense *if* the regulations are adopted. Both bills are in the House Professional Licensure Committee.

Financial disclosures (HB-773)—The Physician's Financial Disclosure Act would require disclosures to patients when a physician has a significant beneficial interest in an organization to which the patient is referred. The bill is in the House Health and Welfare Committee.

Generic prescriptions (SB-640)—This amendment to the Pharmacy Act would permit changes in a prescription when approved by the patient, rather than by the prescriber as required by current law. It is in the Senate Public Health and Welfare Committee.

The authors are the staff of the Council on Legislation. Mr. Craig is director. Mr. Rothenberger is assistant director, and Mr. Light is legislative liaison.

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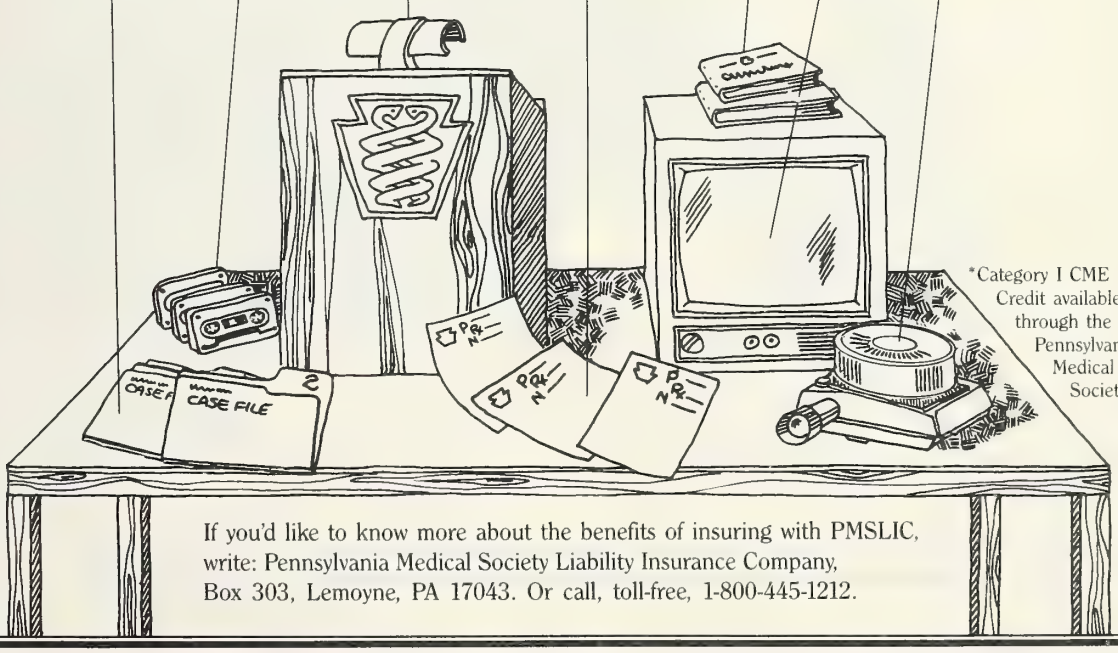

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Medical records and confidentiality (HB-811)—The Health Information Act would prohibit disclosure of medical records except to the patient, to certain employees, in emergencies, or under court order. It is in the House Health and Welfare Committee.

Medical records and access (HB-812)—This Patient's Right to Know Act would assure access to the health information which is in the custody of a health care provider. It is in the House Health and Welfare Committee.

Sunset of other boards:

1. *Physical Therapy*—HB-1363 has passed the House (201-0) and is now in the Senate Consumer Protection and Professional Licensure Committee. The Society is investigating the need for technical amendments which would restrict possible expansion of the practice.

2. *Chiropractic*—HB-1362 has also passed the House (200-1) and is in the Senate Consumer Protection and Professional Licensure Committee.

3. *Nursing*—Legislative action is scheduled to begin this fall by the Senate Consumer Protection and Professional Licensure Committee.

4. *Optometry*—Following a series of hearings on the use of therapeutic drugs by optometrists and restrictions on opticians who fit contact lenses, action is scheduled by the House Consumer Protection Committee in the fall.

5. *Pharmacy*—Senate Bills 818 and 254 propose comprehensive amendments to the Pharmacy Act. SB-254 is identical to a bill from last session that was amended to meet PMS concerns. SB-818 was drafted by chain pharmacies.

Legislation enacted in this session:

Physician License Suspensions, SB-338 (Act 7) and SB-340 (Act 9) provide that MDs and DOs who are convicted on drug felony offenses will face an automatic license suspension.

Temporary Suspension, SB-83 (Act 6) provides for a temporary suspension of an MD license when the medical board determines that the physician is a "clear and eminent danger to public health and safety." Suspensions also are required for violations regarding acceptance into medical schools.

Malpractice Misconduct, SB-81 (Act 48) amends the Health Care Facilities Act to require reports by hospitals of discipline for professional misconduct, malpractice, or conviction on a felony charge. It was signed this summer.

EMS/Ambulance Licensure, Act 45 (SB-632) was passed in late June. The new law establishes a program to license ambulances and emergency personnel. It also extends the Pennsylvania Trauma Systems Foundation.

Medical Assistance budget: The 1985-86 General Appropriation Bill signed by the governor contains the following language implementing an increase sought by PMS and HAP: "On July 1, 1985, the Department of Public Welfare shall adjust the Medical Assistance fee schedule so that rates for a physician office visit and hospital outpatient and emergency use of the emergency room are 70 percent of the average usual charges submitted to the department." The additional funds necessary to fund that increase, up from 20 percent of average usual charges of two years ago, also was included.

Conclusion—It is expected that the September and October legislative activity will be extremely intense. The Council on Legislation will monitor the positions of individual legislatures on these health bills as a basis for candidate support decisions for the 1986 elections. □

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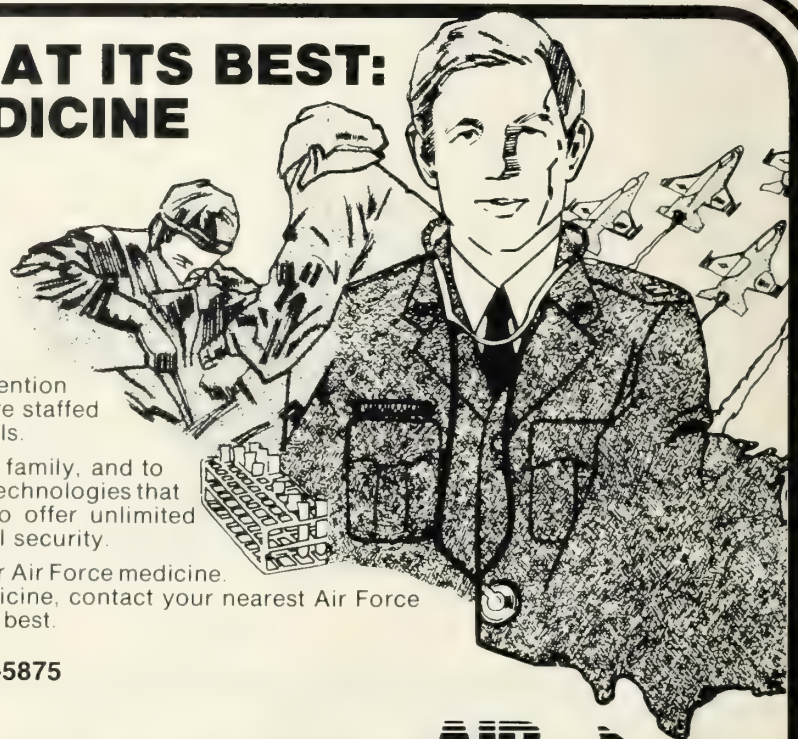

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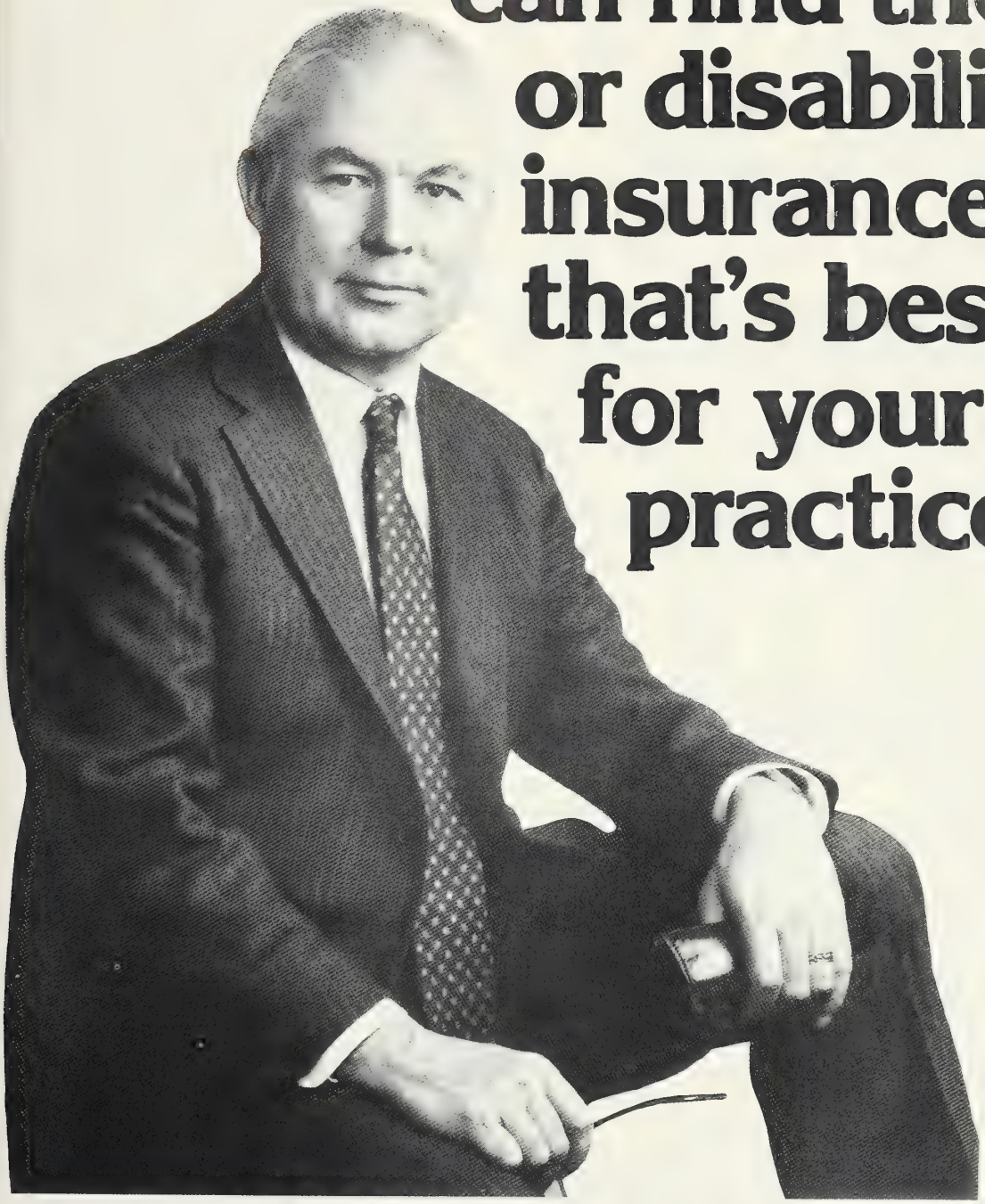

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special feature

AMA House acts on dominant issues

R. William Alexander, MD

Organization finances, professional liability issues, the supply of physicians, the public's perception of the profession, and issues relating to public health were on the agenda at the 1985 Annual Meeting of the AMA House of Delegates.

AMA finances

The House of Delegates adopted a $45 increase in regular membership dues effective in 1986. The increase, which brings dues to $375 a year, allows for the resumption of programs which were delayed or reduced in 1985 and the investigation of new initiatives to maintain the organization's role as the only voice for all physicians nationwide.

The new initiatives will examine ways the AMA can provide leadership and direction in these areas:

- To retain for physicians the role of principal manager of patient care;
- To help physicians provide quality care as efficiently as possible;
- To facilitate creative and cooperative efforts that ensure the economic viability of physician initiated enterprises.

The dues increase also will finance the continuation of effective representation in Washington, aggressive legal representation to protect the rights of physicians and patients in the courts, improvement of the public's understanding of how changes in the medical care system will affect them today and in the future, and efforts to find solutions to the professional liability crisis.

Public awareness

A public awareness study ordered at the 1984 Interim Meeting was received by the House of Delegates. It contains details for specific activities designed to strengthen the Association's communications efforts. The pilot programs, which will cost over $1 million, include baseline surveys of the public's views toward medicine and physicians; the production and evaluation of informational commercial messages; the promotion and distribution of a physician profile film which was previewed by the delegates; public health campaigns; and the establishment of an annual national communications workshop.

Professional liability

As expected, the professional liability crisis occupied much of the delegates' attention. Delegates voted to implement an action plan in the areas of education and community action, legislation, defense coordination, and risk control and quality review. The house also voted to authorize the preparation of a more specific response to the contentions of the Association of Trial Lawyers of America on the current situation regarding professional liability.

Physician supply

The house ordered the formation of a task force on the supply and maldistribution of physicians and the effect on the quality and costs of medical care.

Public health

The house adopted a report from the Council on Scientific Affairs calling for an AMA public information program against the drinking of alcohol by drivers. It also voted support for making a 0.05% blood alcohol concentration *per se* illegal for driving, and for urging the incorporation of that position in all state laws; for legislation establishing 21 as the legal drinking age; and for encouragement of the automobile industry to develop safety mechanisms to thwart efforts to operate an automobile by an intoxicated person.

The house adopted two reports and several resolutions strengthening AMA's position on the use of tobacco products. The reports call for numerous activities including the development of model state legislation restricting smoking in public places and the initiation of programs to discourage smoking.

Other issues

Delegates approved a position statement expressing the AMA's reservations concerning the overall impact of the Diagnosis-Related Group system on the well-being of patients and the capability of hospitals to continue to provide quality care under the system. The statement also encourages the testing of new systems of reimbursement for medical care and calls for continued monitoring of the DRG program and the offering of constructive recommendations to assure the quality of care for patients.

An interim report on the AMA's efforts to secure a grant to develop a relative value scale was presented to the house. The report emphasized that a relative value scale is not a fee schedule. The AMA will continue its strong opposition to the implementation of any mandatory fee schedule. The effort to obtain a grant from the Health Care Financing Administration to develop a resource cost-based relative value scale for physicians' services will continue.

Conclusion

The medical profession faces greater challenges today than ever before. In the face of those challenges, America's physicians need and deserve a strong national medical organization.

It is necessary for effective representation in Washington. In 1984, the AMA made over 3,200 contacts with Congress, the White House, and federal regulatory agencies.

It is necessary for aggressive legal representation. Protecting the rights of physicians and patients in the courts from growing intrusion by government and other entities is a long-standing and essential AMA activity.

It is necessary to improve the public's understanding of how changes in the medical care system will affect patients now and in the future.

It is necessary to find solutions to the professional liability crisis. The Action Plan of the AMA's Special Task Force on Professional Liability provides some of the solutions, but the effort must continue.

So must the support of physicians continue for the American Medical Association.

Dr. Alexander is president elect of the Pennsylvania Medical Society and chairman of the Pennsylvania Delegation to the AMA.

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Colloid cyst of the third ventricle

C. Darrell Lane, MD
Gregory J. Lignelli, MD

A case of sudden unexpected death in an adult (SUDA) due to acute hydrocephalus and subsequent brain infarction produced by a colloid cyst of the third ventricle is presented. The clinical symptomatology, diagnostic approach and pathology are discussed. The evaluation of headaches in the absence of trauma or other obvious etiology determined by careful history and physical examination should include CT scan as a highly sensitive technique for determining the presence or absence of an operable intracranial tumor. These benign lesions are rare, and expedient diagnosis with surgical intervention usually is curative. Failure to establish the diagnosis may result in the presentation of a patient with irreversible brain damage or sudden death.

Colloid (paraphyseal; neuroepithelial) cysts of the third ventricle are uncommon intracerebral tumors representing a congenital malformation which usually does not produce symptoms until early adult life. Although these histologically benign cysts may occasionally remain entirely asymptomatic, their more traditional presentation consists of a constellation of symptoms which can be quite variable, sporadic, rapidly progressive, and frequently fatal.[1-7] This case represents sudden and unexpected death in an adult (SUDA) associated with massive brain infarction secondary to acute hydrocephalus produced by an obstructing third ventricle colloid cyst.

Case report

A seventeen year old white male high school student was evaluated in April following the acute onset of severe episodic bilateral frontal headaches. No etiology was determined, the headaches abated, and the patient was discharged following negative neurologic and ophthalmologic evaluation and empirical treatment for sinusitis. During the ensuing summer he did heavy labor and returned to high school in September. One week prior to the final hospitalization in mid-September the headaches resumed, failed to respond to analgesics administered at home, and were associated with vomiting two days before he lapsed into coma.

When his parents were unable to arouse him during the early morning hours on September 14, he was taken to the local emergency room where physical examination revealed an unconscious teenage boy with dilated fixed pupils, irregular respirations, a blood pressure of 210/120 mm Hg, marked flaccidity, and complete areflexia.

After inserting an endotracheal tube

Dr. Lane is a pathologist at the Reading Hospital and Medical Center. Dr. Lignelli is staff neurosurgeon at Pottstown Memorial Medical Center. *The authors would like to thank photographer Ronald Endy, Ms. Laurie Feick, and the histopathology technologists for their contributions to this report.*

Figure 1 Ventriculogram showing marked dilatation of lateral ventricles with a prominent soft tissue mass (colloid cyst) obstructing the interventricular foramina of Monro. Note lack of air in third ventricle and absence of calcifications.

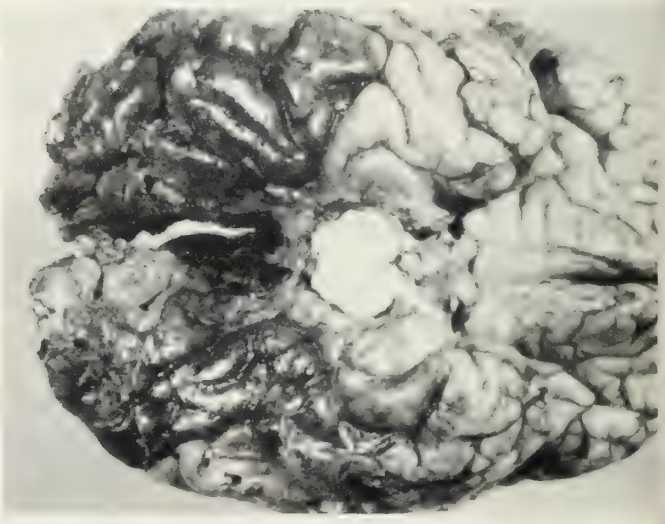

Figure 2 Ventral surface of formalin fixed edematous brain with bilateral cortical ischemic infarcts due to posterior cerebral artery compression.

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to facilitate respirations he was transferred to the Reading Hospital and Medical Center. Upon confirmation of the physical findings an emergency twist drill right ventriculostomy was performed revealing crystal clear ventricular fluid under markedly increased pressure. Following decompression the blood pressure immediately fell to normal (110/70 mm Hg), but the neurologic status remained unchanged. Subsequently a ventriculogram and right brachial arteriogram revealed severe dilatation of both lateral cerebral ventricles, compression of the basilar artery and posterior cerebral arteries bilaterally suggesting hippocampal herniation, and a non-calcified third ventricle soft tissue mass blocking the interventricular foramina of Monro (Figure 1).

The sterile ventricular fluid contained 12 non-leukocytic degenerated cells/mm, 84 mg/dl glucose, 13 mg/dl protein and non-reactive VDRL. Blood chemistry values, urinalysis, chest x-ray, and electrocardiogram were normal. The neurologic pathology was considered irreversible, and the patient expired the following morning less than twenty-four hours after admission.

The autopsy performed one hour after death on the unembalmed body of a well developed, well nourished teenage white male demonstrated a needle puncture wound of the right fronto-parietal scalp at the site of the uncomplicated ventriculostomy, bilateral conjunctival petechial hemorrhages, and a small amount of pink frothy tracheobronchial tree edema fluid. The edematous brain weighed 1,660 grams with the cerebral hemisphere cortex exhibiting marked vascular congestion, flattened gyri, obliterated sulci, severe bilateral uncal notching and cerebellar tonsillar herniation with coning and tenting deformity of the superior surface. Bilateral ischemic infarction of the temporal and occipital cerebral hemisphere inferior cortices corresponded precisely to the anatomic blood supply distribution of the posterior cerebral arteries which were occluded by downward compression of the edematous brain (Figure 2).

Coronal sections displayed extensive infarction necrosis of the inferior medial striatum and ventral diencephalon, areas of the mid-brain supplied by the thalamoperforating and posterolateral (thalamogeniculate) arterial branches of the posterior cerebral arteries (Figure 3).

A discrete 1.5 cm firm, smooth, delicately encapsulated gray-white spherical cyst suspended beneath the corpus callosum was located within the septum pellucidum beneath the cavum (Figure 4). This mass obstructed the interventricular foramina (Monro), showed no gross evidence of recent or antecedent hemorrhage and was intimately associated with the choroid plexus. Conventional light microscopy revealed a compressed fibrous connective tissue cyst wall supporting a monolayer of both ciliated and non-ciliated low columnar epithelium. The homogeneous gelatinous milky white contents stained eosinophilic on H&E, reacted positively with Mayer's mucicarmine and periodic acid-Schiff (Figure 5) techniques and contained small aggregates of erythrocytes, neutrophils, lymphocytes, isolated epithelial lining cells and cellular debris. Scattered fusiform cholesterol clefts suggested antecedent hemorrhage into the cyst. There were no calcium deposits. Reticulin and trichrome stains confirmed the presence of scanty connective tissue in the cyst wall. Elastic stains failed to demonstrate elastic connective tissue as noted by Malik *et al.*[3]

Discussion

Although colloid cysts are reported to comprise up to 2 percent of all intracranial gliomas[2,4] including lesions removed surgically, tumors eventuating in sudden death and asymptomatic lesions found incidentally at autopsy, their actual occurrence may be considerably less frequent. The surgical pathology files of the Reading Hospital and Medical Center record no colloid cysts in 508 supra and infratentorial brain tumors from 1964 through 1983, and this case report is the only example of colloid cyst diagnosed in 6,745 autopsies in the same period. Hospital deaths as well as medicolegal postmortem examinations performed at the request of the Berks County coroner are included. Although cranial vault examinations were not performed in every case, brain necropsies were included whenever there was a reasonable probability of central nervous system pathology and where permission for examination was not specifically denied.

Sudden and unexpected death from primary intracranial neoplasms is an infrequent event. In one series of 17,404 autopsies from the Brooklyn, New York Medical Examiner's office from 1960-1970 there were 28 (0.16 percent) such

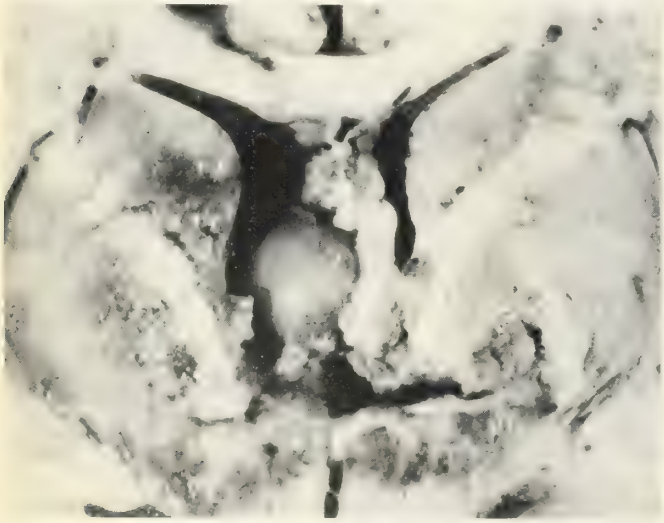

Figure 3 Thalamus, hypothalamus, and basal ganglia ischemic necrosis is shown. Colloid cyst visualized in third ventricle.

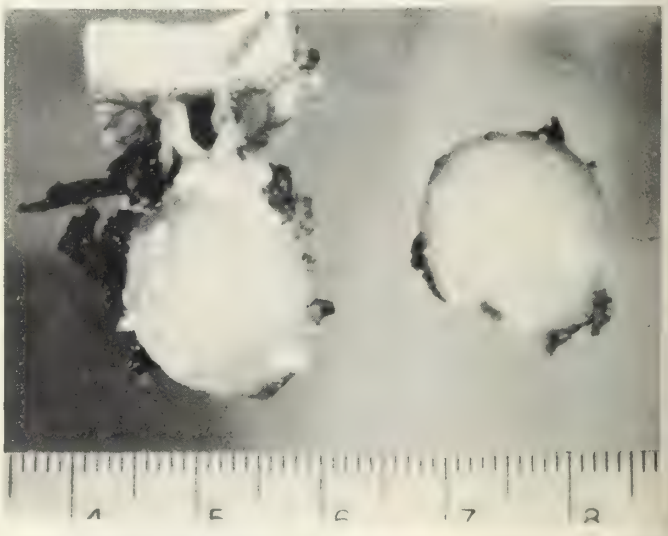

Figure 4 Sectioned cyst in septum pellucidum exhibits gray-white opaque colloid contents.

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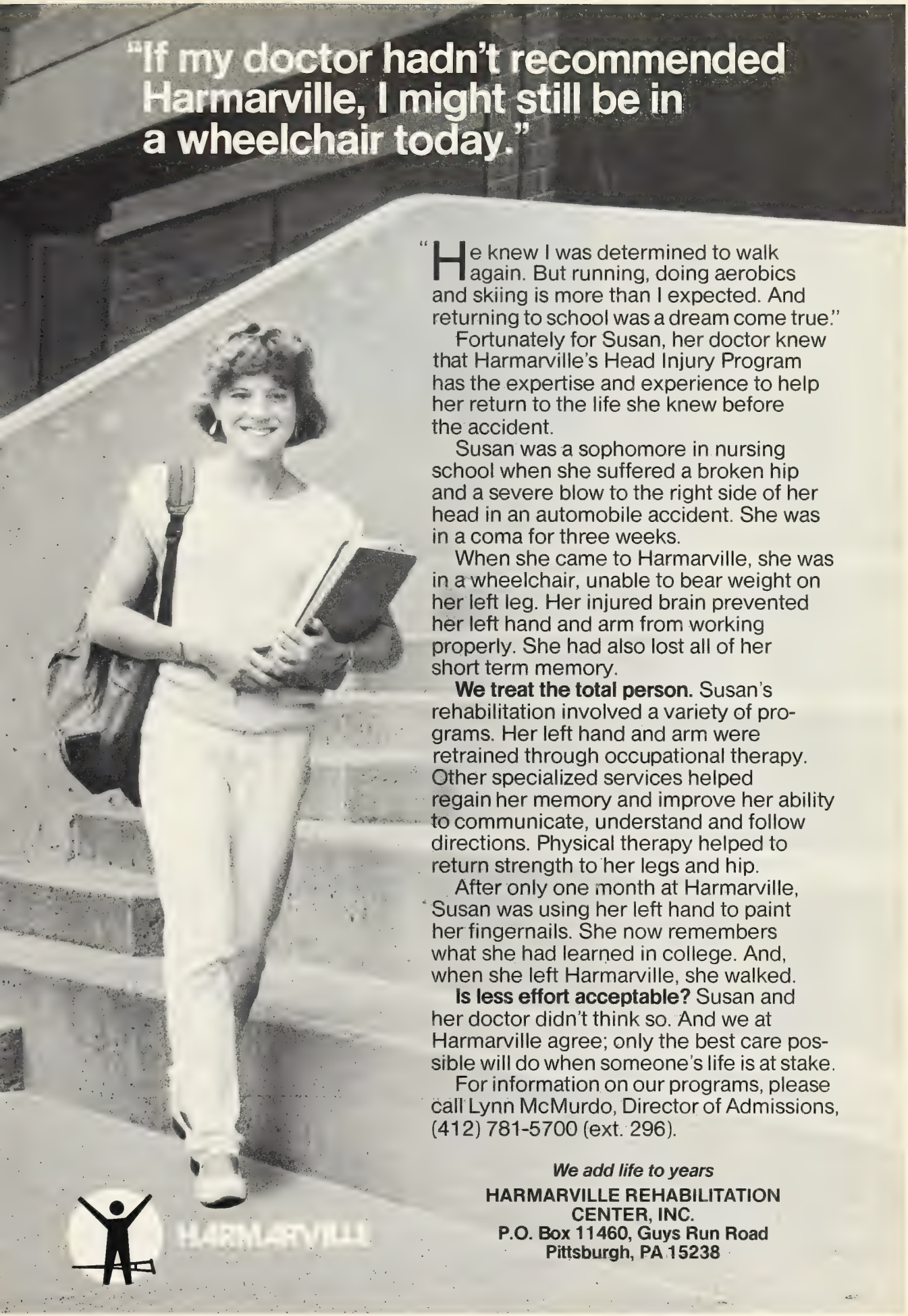

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deaths,[1] and a similar study from the Dallas County Medical Examiner's office from 1970-1977 representing 10,995 medicolegal autopsies revealed 19 (0.17 percent) deaths.[5] Huntington *et al*[8] encountered no colloid cysts in a series of 109 primary intracranial tumor deaths representing a review of 24,511 autopsies. Lundberg and Voigt recorded no intracranial neoplasms in their limited series of 100 consecutive sudden unexpected deaths in adults in Sweden.[9]

The chief complaint of headache presents a simultaneously common and perplexing problem for physicians, and the definition of a specific etiology frequently remains an enigma. Consequently pursuit of a thorough, expensive, and often unrewarding evaluation has attracted recent criticism with regard to cost-effectiveness,[10] and is a particularly sensitive subject in this era of diagnosis related groups (DRGs). While this contention contains some merit, had ventriculography been performed or the technology of computerized tomography (CT scan) been available during the first hospitalization the probability of establishing the correct diagnosis would have been greatly enhanced and the subsequent tragic outcome probably averted.[14]

The necessity for a thorough diagnostic evaluation in quest of these obviously rare lesions is defined by the situational circumstances, namely sudden onset of intermittent severe headaches interspersed by asymptomatic periods in a young adult, absence of other obvious etiology, sometimes but not invariably a positional association to the intensity of the headache, a negative physical examination and a high index of suspicion.

There is no apparent sex predisposition, symptoms usually begin in the second or third decade, and the patients have heretofore enjoyed good health or have at least had no specific neurological problems. Exceptions do exist as exemplified by transient episodic quadriparesis in a 63 year old man produced by periodic hemorrhage into a colloid cyst[3] and by presentation as a psychiatric disorder without headaches in a 24 year old woman.[11]

The embryologic origins, growth and development of these lesions have been under investigation for years with the scholarly report of Ariens Kappers serving as the most detailed early treatise with which all successive research is compared.[12] Since this report a number of attractive theories have been advanced, none of which has thus far been universally accepted as inclusive or definitive. Until incontrovertible evidence regarding origin becomes available the conventional nomenclature of colloid cyst of the third ventricle should remain the preferred terminology. "Colloid," meaning gelatinous or mucinous, aptly describes the gross appearance of the lesion while avoiding advocacy of any one specific but unproven developmental hypothesis.

Figure 5 **Monolayer of low columnar epithelium divides cyst wall formed by loose connective tissue from dark staining colloid cyst contents (PAS, X200).**

Although the precise pathophysiology of the adult appearance remains uncertain a reasonable theory postulates gradual enlargement due to active fluid transport by the cyst lining epithelial cells with subsequent obstruction of the interventricular foramina. The presence or absence of cilia does not permit determination of the nature of the lining cells, and both cell types share light microscopic and ultrastructural characteristics with normal choroid plexus epithelium.[13]

Once symptomology representing interventricular foramina obstruction with acute hydrocephalus develops a true surgical emergency exists. Unless the diagnosis is established without delay followed by expedient surgical removal the opportunity for definitive, curative treatment may be lost. Little and MacCarthy report 5 operative related deaths in a series of 21 colloid cyst patients with 12 of the 16 survivors experiencing complete recovery. Two patients required medication to control convulsions, and two patients with hydrocephalus received permanent shunts.[6] Surgery remains the only effective therapy, and the results are encouraging when compared with the probable eventual fatal consequence.

One additional interesting facet of this case must be noted. Eighteen months following the death of this patient his thirteen year old brother presented with a posterior fossa tumor which subsequently proved to be a medulloblastoma. He has remained asymptomatic ten years after surgery. In one earlier series two patients had co-existing glioblastoma multiforme.[4] No other family associated brain tumors were discovered in our literature review. It appears at this time that associated brain tumors present as curious coincidental occurrences with no apparent inherited predisposition, although these situations are worthy of notation for possible future investigation.

Colloid cysts of the third ventricle are rare brain tumors which have a speculative and somewhat controversial origin, usually become symptomatic in early adult life, require prompt diagnosis and surgical removal, and may eventuate in sudden unexpected death if not aggressively pursued.

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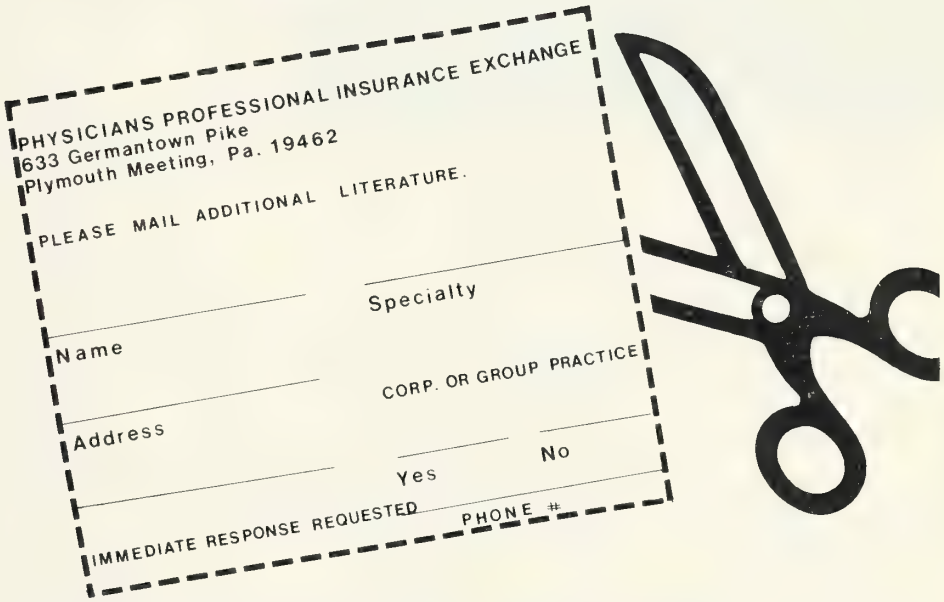

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practice management

Manager of small practice faces unique problems

Dorothy R. Sweeney
Leif C. Beck, LLB, CPBC
Geoffrey T. Anders, JD, CPBC

Medical office managers have long been a vital part of mid to large size group practices, but the complexity of the business side of medicine is now requiring solo and small groups also to have a lay person in charge. Very often, the manager of the smaller practice has a difficult assignment, especially if he or she is promoted from within the ranks.

In smaller practices the interpersonal relationships among medical assistants are often quite close, partly because of each employe's dependence on the other for job success. Thus a new office manager promoted from among peers faces the unique problem of taking charge over people who previously were equals. Physicians directing the change may not be aware of the potential problem and as a result often are surprised when a previously congenial atmosphere becomes strained.

The newly promoted manager naturally tends to continue the same friendships and social contacts with former co-workers. Yet this can be uncomfortable for both new manager and staff members, particularly if there is some resentment over "one of their own" having been put in charge. Bad feelings can arise out of frustration when neither side quite knows what to do or how to act, and the new manager may find it difficult to develop leadership in this environment.

While not espousing a class distinction among categories of employes, most managers find it necessary to maintain a separation from other staff—especially avoiding being "one of them" for all social occasions. It is simply easier to perform supervisory duties when not part of the same social scene.

Office managers promoted from within often have initial feelings of isolation when they first assume supervisory roles. Former peers do not treat them quite the same, but neither are the managers on the same level with the doctor(s).

The doctor(s) can help this transition tremendously by being supportive during the initial period until the new manager's role fits the right style for the office. The doctor should smooth the path by identifying the manager's duties and authority and by making the delegated authority clear to the rest of the staff. While time by itself will help sort things out as everyone becomes accustomed to the new manager, the doctor's early support can be invaluable.

Clinical supervision

Another problem that a newly appointed manager faces is often the question of who is "in charge of" the clinical staff. Clinical employes will often place themselves on a pedestal above the receptionists, billing clerks, and secretaries. They then claim to be responsible only to the doctor(s), outside the authority of a practice's manager. This cannot be permitted in any situation, but it is disastrous in a small practice.

While only a physician might supervise a nurse as to actual work with patients, the nurse nevertheless should be directly responsible to the office manager. Work hours, room assignments, salary levels, authorized absences, relations with other employes, and the like must all be within that manager's responsibility. And the manager should be authorized to assign a nurse to clerical duties whenever she is not busy with patients. Nurses and technicians cannot place themselves above helping out as if other tasks were beneath them.

The physician(s) must support the manager's exercising such overall authority. When a nurse directly complains to the doctor or requests special handling, the reply must be to discuss it with the manager. Undercutting such supervisory authority will simply invite "the front versus the back syndrome." That is all too prevalent in many medical practices.

"Insider" responsibility

Any newly hired or promoted office manager should be considered an "insider" and included in any business meetings, with responsibility for the success of those meetings. At the meeting the manager's task should be to report on the business, presenting and discussing the most recent financial report and any concerns or recommendations. There should be a progress report on matters previously decided, as a means of tracking progress.

Physician's business meetings are notoriously unproductive, but intelligent use of the office manager can dramatically upgrade the effectiveness of such meetings. The manager should see each doctor several days in advance to determine what items the doctors want discussed. Then a meeting agenda can be made and distributed for study before the meeting. At the meeting, the manager should take notes and remind various doctors afterwards of things they had agreed to handle. In this respect, the manager can help the doctors become better "doers."

Perhaps even more importantly, the manager can assume responsibility to carry out decisions made at the doctors' meetings. The manager is more likely to implement decisions in timely fashion and the doctors' time is free for other demands. The undertaking and its subtleties will be far better understood if the manager participated in the meeting than if bare instructions were given afterwards.

Some doctors consider their practice finances so confidential that even the

The authors are among the principal consultants of the Health Care Group, management consultants in Bala Cynwyd.

office manager is not privy to them. We consider this attitude extremely unwise, for there is nothing to gain from such confidentiality. Instead, participating in the financial planning and monitoring makes the manager more of an "insider," able to apply the economics to office decisions.

How busy should your manager be?

Finally, the question often is asked in the smaller settings—why do I need someone just to manage my practice. And, as practices face some tough economic concerns in the next few years, more and more physicians probably will ask this question.

"The busier the manager appears to be the less effective he or she actually is in performing the job; and the better the office is actually running, the less busy the manager will appear to be." Let us describe why the slogan usually holds true.

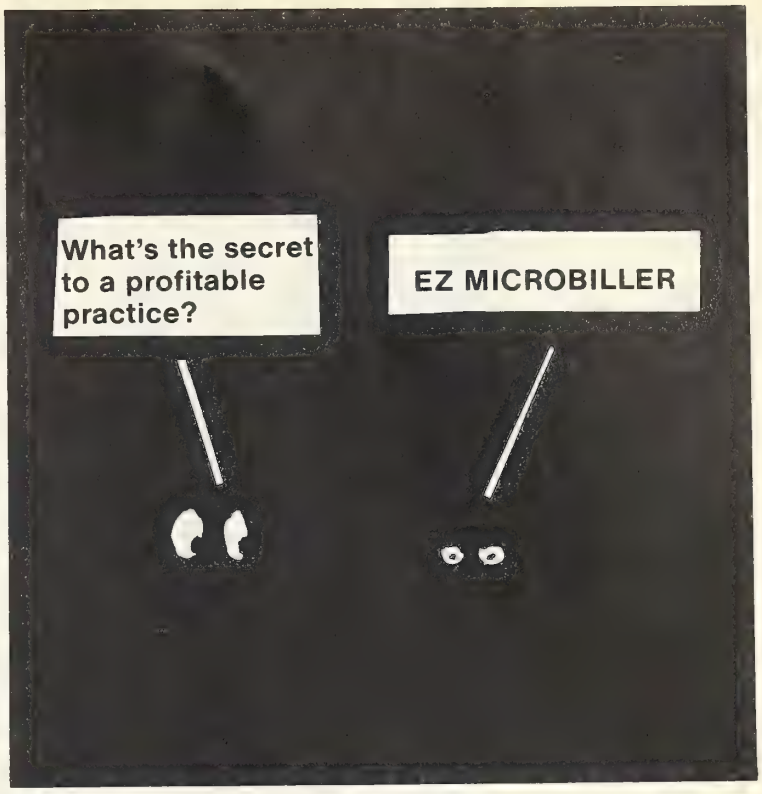
A manager's duty is to delegate responsibility and to supervise employes actually handling the work. That highly paid person should be creating an office environment in which each task is handled by the lowest paid person able to do the job effectively. Once all the tasks are handled by the properly selected and trained people, the manager's minute-to-minute demands should be replaced by broader planning challenges.

The manager who routinely handles the reception desk or billing work in a regular employe's absence may well be guilty of poor management. Office systems should be structured with cross-training and access to substitutes so all jobs will be handled even in crisis situations. It is far better that the manager anticipated the problems and planned how to handle them than that he or she had to plug the gap personally.

Physicians should be critical of managers who are too much involved in the actual jobs. Such people may seem loyal and devoted but they may also be failing their important duty—to make the office and the practice function as smoothly and effectively as possible.

Conclusion

Office managers, even in smaller practices, are vital to success. The newly hired or promoted manager of the smaller practice has some unique concerns. Open communication between physician(s) and manager is essential as both try to become comfortable in their prospective roles. □



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medical feature

Syphilis in rural Pennsylvania

Johnson W. Martin, PhD

Nationwide in 1947 there were 106,539 cases of primary and secondary syphilis reported. That year was followed by a persistent decline in reported cases reaching a low of 6,575 in 1957. Beginning in 1958 the incidence of reported primary and secondary syphilis began to rise and in calendar year 1983 there were 32,038 cases reported nationally.[1] Pennsylvania reported 569 cases in 1983, 405 of which were from Philadelphia.[2] Clearly the remaining 164 cases distributed across Pennsylvania did not provide most physicians an opportunity to diagnose cases of syphilis.

The Pennsylvania Department of Health maintains a staff of disease intervention specialists as part of its mandated public health effort to control and reduce the incidence of sexually transmitted diseases (STDs) in the Commonwealth. Among their duties, these disease intervention specialists provide consultation to physicians, assist in staffing of public clinics and perform contact tracing investigations on all reported cases of infectious syphilis. As a result of these investigations, a chain of related syphilis cases was discovered between May 1983, and January 1984. Because of the ages of the individuals involved and their geographic distribution, these syphilis cases provide an exceptionally instructive example of the medical and psychosocial aspects of this communicable disease.

Report of cases

In late May 1983, a 27-year-old male was arrested in southeastern Pennsylvania and imprisoned on charges of attempting to sexually molest an 8-year-old boy in a public restroom. Upon entering prison, a routine serologic test for syphilis was performed on the prisoner, and the test results were reactive, an RPR of 1:512 dilutions and a reactive FTA-ABS.[3]

He had no symptoms or physical findings at the time of his incarceration and had no recent serologic tests. He disclosed a homosexual lifestyle of mixed active and passive sexual behavior. He reported that he had lived in Tennessee until August 1982 when he returned to his parents' home in southcentral Pennsylvania. He resided with his parents until October 1982 at which time he moved to southeastern Pennsylvania. He named three men in Tennessee and four men in southeastern Pennsylvania with whom he had sexual relations in the previous twelve months. As a result of the subsequent investigation, only two of these sexual contacts were located. Their serologic tests for syphilis were negative, but because of their recent exposure and the possibility that they could be incubating the disease they were treated prophylactically.

Over one month later, on July 19, two men were examined and treated for syphilis by a physician in northeastern Pennsylvania. One of these men had a reactive RPR of 1:32 dilutions and had a classic palmarplantar maculopapular rash. The other had a reactive RPR of 1:32 dilutions but no pertinent symptomatology. During the investigation of these two individuals it was learned that they had been involved sexually with one of the unlocated sexual contacts of the person described in the previous paragraph. With the additional information obtained from these men, that contact was located successfully. He was examined and diagnosed on July 22 as latent syphilis. He had an RPR of 1:128 dilutions and a reactive FTA-ABS. He denied knowing the names or whereabouts of his sexual partners.

He gave no history of symptoms, claimed to be allergic to penicillin and was treated with tetracycline 500 mg q.i.d. for 15 days. On September 6, 1983, this same man traveled to Philadelphia where he and a male friend from Philadelphia were examined in a sexually transmitted disease clinic. At that time he admitted to being non-compliant in taking the tetracycline and he was treated with 2.4 million units of benzathine penicillin. His male friend was found to have a rectal chancre, a 1:8 dilution RPR and a reactive FTA-ABS and was also treated with 2.4 million units of benzathine penicillin.

On September 21, 1983, an 11-year-old boy from southcentral Pennsylvania was diagnosed as having primary syphilis. His examination revealed a single penile lesion, bilateral inguinal lymphadenopathy, a reactive RPR of 1:1 dilution and a reactive FTA-ABS. The boy denied sexual exposure of any kind. Both parents and a sibling were serologically tested and found to be negative for syphilis. Based on the chronological and developmental age of the boy and the fact that no other cases of syphilis had been reported for that county, it was difficult for everyone involved to believe that this boy had contracted syphilis. Upon further investigation, it was decided that close relatives and playmates should also be screened for syphilis.

Twenty-one were tested and a 15-year-old boy was found to have a reactive RPR of 1:256 dilutions, a reactive FTA-ABS, and a maculopapular rash that had been considered to be acne by him and his parents. He was treated with 2.4 million units of benzathine penicillin on December 14, 1983 and questioned about his sexual partners. With a great deal of reluctance this pubescent male admitted to receiving fellatio from a 15-year-old emotionally disturbed boy. He stated that both he and the 11-year-old boy, already diagnosed, had received fellatio from the 15-year-old during the summer vacation. He

The author is public health program representative for the Sexually Transmissible Diseases Program of the Pennsylvania Department of Health. *He wishes to thank Ms. Bonnie K. Forry for her help with interviewing the syphilis patients.*

also indicated that other adolescent males had similar sexual contact.

The emotionally disturbed boy was examined and treated on January 5, 1984, and found to have a reactive RPR of 1:512 dilutions. He had no symptoms at the time of examination and no history of symptomatology. He claimed to have never engaged in any kind of sexual behavior. He did admit to having been told that he did "wild" things when he drank beer but he could not remember the details of these incidents. After lengthy questioning he recalled a time when he had been awakened in bed by his uncle. His uncle had then proceeded to perform fellatio on him. When asked who his uncle was, it was learned that the uncle was, in fact, the same person who on May 30, 1983, was arrested in a county 100 miles away for attempting to sexually molest an 8-year-old boy in a public restroom.

This chain of infection, as shown in Figure 1, beginning in Tennessee and carried to rural Pennsylvania should serve to remind health care providers to be vigilant for sexually transmitted diseases. There are several important issues raised by the occurrence of syphilis in these boys and men.

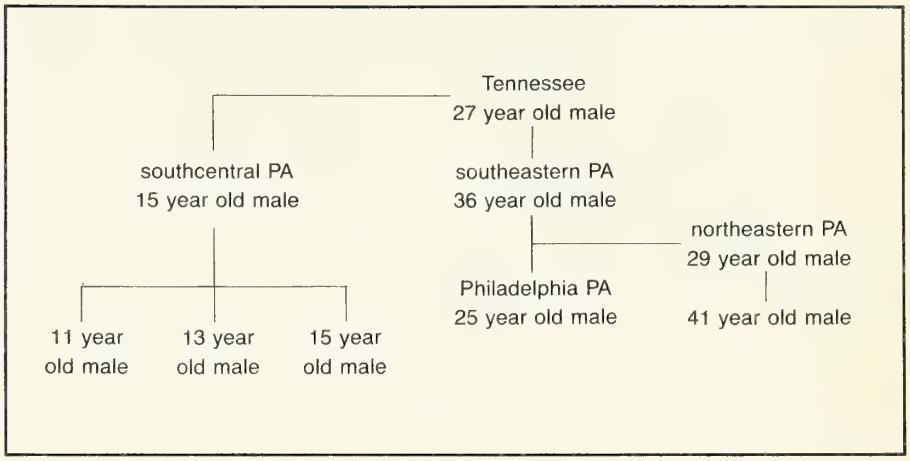

Figure 1 **Chain of related syphilis cases originating in Tennessee and imported to Pennsylvania by a 27 year old male homosexual**

Discussion

First, it is good medical practice to identify people at risk of acquiring sexually transmitted diseases and afford them an opportunity to receive routine testing. This determination should be made by the physician based on information provided by the patient. All people arrested for sex offenses should be tested for syphilis and gonorrhea.[4]

Second, we must be objective in assessing patient needs. In 1983, men accounted for 79 percent of the reported syphilis in Pennsylvania and syphilis ranked 7th among reportable communicable diseases, surpassed by gonorrhea, hepatitis, salmonellosis, tuberculosis, giardiasis, and shigellosis.[5] Because all of these infections can be transmitted sexually and because of their increasing prevalence among male homosexuals and bisexuals, care should be taken to determine the sexual preferences and practices of patients.

Third, there were 15,812 reports of child abuse in Pennsylvania in 1983. Of those reported, 5,623 were substantiated instances of child abuse and 2,629 involved sexual abuse.[6] These figures indicate a substantial need to be alert for suggestive symptomatology regardless of the denial of abuse by family members.

Fourth, in 1983 in Pennsylvania, 400 children under age 15 were reported to have gonorrhea and 26 were diagnosed as having syphilis. Only 3 counties in Pennsylvania did not report cases of either.[7] We are all cognizant of the early age at which many adolescents become sexually active.[8] We should strive to provide for them the same responsible confidential care we ourselves would want and which has been mandated for them by public law.[9]

Pennsylvania ranked 26th among the 50 states in the incidence of reported infectious syphilis in calendar year 1983. With the majority of those cases concentrated in Philadelphia, Harrisburg, and Pittsburgh, chances are that most health providers will not diagnose patients with syphilis. Yet as evidenced by the infections described in this article, syphilis as well as all sexually transmitted diseases can be imported and spread very quickly in any sexually active community. Health care providers must assume the responsibility to identify those patients in need of specific tests for sexually transmitted diseases. □

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Home intravenous antibiotic therapy

John P. Manzella, MD
John H. McConville, MD
Barbara Klaus, RN
Thomas Brenner

York Hospital is a 573-bed community hospital that serves as a primary care center as well as a referral center for patients with complex medical problems. In order to reduce the length of hospital stay and permit medically stable patients to minimize time lost from work, education, and personal activities while treatment is continued, the home intravenous antibiotic program (HIVAP) was instituted in June 1982. As of October 1983, 45 patients have participated. These 45 patients have received a total of 52 courses of antibiotic therapy. We report our experience with home therapy and describe the structure, evaluation, and follow up procedures of the HIVAP at York Hospital.

Patients and methods

The HIVAP team consists of specialists in infectious diseases, members of the social services department, members of the department of pharmacy, and the HIVAP instruction nurses. Patient identification for participation is the responsibility of the patient's attending physician. The decision is made by the attending physician and a member of the division of infectious diseases. The program has been restricted to medically stable patients requiring two or more weeks of intravenous antibiotic therapy, although some exceptions for shorter courses have been made.

After the patient has been identified as a possible participant in the program, the social services department begins an investigation of the patient's home environment, his ability to pay for home intravenous antibiotic therapy, and other relevant factors that may have a bearing on the patient's suitability. Adequate insurance coverage for payment of expenses incurred during home I.V. therapy is a basic criterion for determining eligibility for the program.

Accepted patients have two or three sessions with the team instruction nurse before discharge. All patients are taught to administer the intravenous antibiotics before they go home. Patients learn the principles of aseptic technique and intravenous cannula care. The infectious diseases physician and home instruction nurse review the possible untoward effects of the antibiotics, the symptoms of worsening infections, and symptoms of intravenous associated phlebitis. Replacement of the heparin locks is done when necessary during the course of therapy. Patients pick up antibiotic supplies two days a week, are examined at that time by an infectious diseases physician, and have the intravenous line checked and changed if necessary. If the intravenous line infiltrates, or phlebitis develops between these days, the patient returns to the emergency room to have the intravenous line changed. Appropriate laboratory studies, depending on the patient's infection and antibiotic therapy, are obtained during the course of antibiotic therapy.

Drugs and supplies

All antibiotic solutions are mixed in advance by the hospital pharmacy. Patients are supplied with intravenous tubing with drip chambers, alcohol swabs, heparin flush wells (100 units per ml) and hypodermic syringes.

Cost analysis

The estimates of daily hospital room charges, physician fees, cost of antibiotics and supplies, and the cost of outpatient medical care were used to deter-

The authors are associated with York Hospital. Drs. Manzella and McConville are physicians in the division of infectious diseases. Ms. Klaus serves in the nursing department, and Mr. Brenner is director of pharmacy.

Table 1
Diagnoses in 45 Patients

	n	%
Osteomyelitis	28	(62)
Endocarditis	6	(13)
Hickman catheter infections	4	(9)
Miscellaneous	7	(16)

Table 2
Mean Age of Patients and Duration of Therapy

Year	Mean age (yrs.)	Mean duration of therapy (days)
1982	46 (18-70)*	23
1983	43 (3½-78)	18
Mean	45	20.5

*Age ranges

Table 3
Organisms Isolated in 52 Courses of Therapy

	n	%
Staphylococcus aureus	21	(37.5)
Aerobic, gram negative bacilli	13	(23)
Staphylococcus coagulase negative	12	(21)
Streptococci	7	(12.5)
Corynebacterium sp.	2	(3.5)
Anaerobic, gram positive cocci	1	(2)

Table 4
Antibiotics Used in 52 Courses of Therapy

Antibiotic	Courses	Adverse effects*
Cefazolin (Ancef)	12	0
Nafcillin	12	2
Aminoglycosides	8	1
Vancomycin	7	0
Penicillin G	5	1
Cefoxitin (Mefoxin)	5	0
Cefoperazone (Cefobid)	4	1
Cephalothin (Keflin)	3	0
Ticarcillin	1	0
Ampicillin	1	0
Clindamycin	1	0

*See "Results" for details

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FALL 1985

October 2	9:00 A.M.	Clinical Pathology Conference
October 2	12:15 P.M.	CME Conference: Clinical Aspects of Beta Blockers **Bernard Segal, M.D.** *Director, Cardiovascular Institute* *Hahnemann University Hospital*
October 9	9:00 A.M.	Clinical Rounds: Pulmonary **Robert Michaelson, M.D.** *Section of Pulmonary Disease, Jeanes Hospital*
October 16	9:00 A.M.	Morbidity and Mortality Conference
October 23	9:00 A.M.	Tumor Conference
October 23	12:15 P.M.	Outpatient Management Conference: Diabetes Mellitus
October 30	9:00 A.M.	Clinical Rounds: Dermatology **Charles H. Greenbaum, M.D.** *Section of Dermatology, Jeanes Hospital*
November 6	9:00 A.M.	Clinical Rounds: Endocrinology **Andrew Quint, M.D.** *Section of Endocrinology, Jeanes Hospital*
November 6	12:15 P.M.	CME Conference: New Drugs for Treatment of Asthma **Mark Kelly, M.D.** *Cardiovascular-Pulmonary Division* *Hospital of the University of Pennsylvania*
November 13	9:00 A.M.	Clinical Rounds: Gastroenterology **William Battle, M.D.** *Section of Gastroenterology, Jeanes Hospital*
November 20	9:00 A.M.	Morbidity and Mortality Conference
November 27	9:00 A.M.	Tumor Conference
November 27	12:15 P.M.	Outpatient Management Conference: To Be Announced

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mine the average cost savings for each course of outpatient therapy. The cost of laboratory studies was not used in this cost analysis. The net cost savings for a course of treatment was determined by subtracting outpatient expenses from the hospital cost.

Table 5
Cost Analysis—52 Courses Rx

	Average hosp. cost*	Average outpt. cost†	Average net savings/course
1982	$5,648	2,084	3,600
1983	$4,509	1,462	3,047

* *Includes daily room fees, physician fees, antibiotics and supplies*
† *Same as * except for room fee*

Results

Forty-five patients participated in the program between June 1982 and October 1, 1983. An additional six patients were considered for the program but were rejected for either lack of adequate family support or financial considerations related to insurance coverage that paid for inpatient but not outpatient therapy.

The diagnoses of the 45 patients are shown in Table 1. 62% of the patients had osteomyelitis; endocarditis was present in 13%, Hickman catheter related infections in 9%, and miscellaneous infections in 16%.

The average age was 45 years. The average duration of outpatient antibiotic therapy was 20.5 days, ranging from 3-99 days (Table 2). The bacteria isolated are shown in Table 3. *Staphylococcus aureus,* aerobic gram negative bacilli, and coagulase negative staphylococci accounted for over 80 percent of the infections. Polymicrobial infections were not uncommon.

The most frequently used antibiotics were cefazolin, nafcillin, and aminoglycosides (Table 3). Combinations of antibiotics were used in several cases. Five of the 52 courses of outpatient therapy had untoward effects including skin rash, neutropenia, and drug related fever. A patient who received gentamicin developed vestibular dysfunction that was slowly improving at the time of this report. No infected intravenous lines were seen, although infiltration requiring a change of the intravenous line did occur in several patients.

The average inpatient cost of each course of therapy was estimated by adding hospital room charges, physician fees, and cost of antibiotic agents and supplies (Table 5). If the patient had remained in the hospital to complete therapy, the average cost in 1982 would have been $5,648.00 compared to an average outpatient cost of $2,084.00. The average net savings was $3,564.00. The average net savings for each course of therapy during the entire period of the study was $3,324.00. Approximately $170,000.00 has been saved since the institution of the HIVAP.

Discussion

Home intravenous antibiotic therapy is not a new concept.[1,2,3] Previous studies have shown that home intravenous antibiotic therapy is an excellent alternative to prolonged hospitalization for medically stable patients. Our study adds to the growing literature in this field. We feel that the team approach to the program is necessary to effectively deal with the patient's medical condition, psychosocial aspects, financial resources, and technical training. With the HIVAP, direct costs, such as hospital room charges, have dramatically decreased. Indirect costs, including the ability of the patient to return to work or the home environment, also have decreased. Intangible costs, such as boredom and loneliness related to long hospitalization, are effectively reduced by this program. As Ramm and Weinstein have written, "it is hoped that this demonstration of the increasing application, safety, and efficacy of home intravenous antibiotic therapy will encourage insurance carriers to provide reimbursement for all patients in such programs."[3] □

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physicians in the news

William S. Tasman, MD has been appointed ophthalmologist-in-chief at Wills Eye Hospital, Philadelphia, and chairman of the department of ophthalmology at Jefferson Medical College of Thomas Jefferson University. Dr. Tasman is a director of the American Board of Ophthalmology and the American Academy of Ophthalmology. He is former chairman of the Eye Section of the Philadelphia College of Surgeons. Dr. Tasman succeeded **Robert D. Reinecke, MD,** who has been named head of the Foerderer Eye Movement Center at Wills Eye Hospital.

Several cardiologists participated in "Heart Disease: Past, Present, and Future," a program presented by Likoff Cardiovascular Institute of Hahnemann University, Philadelphia. **Robert K. Jarvik, MD,** inventor of the JARVIK 7™ artificial heart, and Hahnemann faculty members **Bernard L. Segal, MD; John R. Beljan, MD; Joel Morganroth, MD;** and **Abdulmassih S. Iskandrian, MD,** spoke at the seminar. The event honored the cardiovascular institute's founder, **William Likoff, MD,** who currently is chancellor of Hahnemann University.

Robert Wasko, MD, Allentown, recently was installed as president of the Urological Association of Pennsylvania. Dr. Wasko is chief of urology at Allentown Hospital.

James L. Fitzgerald, MD, Allentown, recently retired after practicing 45 years. Dr. Fitzgerald began his career as a general practitioner in Clarion. Following additional training, he became an obstetrician and gynecologist and started a practice in Allentown. He is former staff president and director of obstetrics and gynecology at Sacred Heart Hospital.

Harold F. Shuster, MD, chief of orthopedic surgery at Germantown Hospital and Medical Center, won the 1985 Jesse T. Nicholson Award given by the graduating orthopedic residents of the University of Pennsylvania for outstanding teaching.

Bryan Stevens, MD, was named Teacher of the Year by the family practice residents at York Hospital. Dr. Stevens has been a member of the hospital's staff since 1977.

Regis M. Maher, MD, retired after 41 years of service to the Uniontown area. Dr. Maher is former president of Fayette County Medical Society.

Herbert E. Cohn, MD, Philadelphia, has been elected president of the Thomas Jefferson University Hospital medical staff. Dr. Cohn is professor of surgery at Jefferson Medical College of the university, and he is vice chairman of the graduate education division of the surgery department. Other new officers of the university hospital's medical staff are: **Leon A. Peris, MD,** president elect; **Francis E. Rosato, MD,** vice president; and **John R. Patterson, MD,** secretary-treasurer.

Frederick B. Wagner, Jr., MD, Nar-

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berth, has been elected to the board of trustees of Thomas Jefferson University. Dr. Wagner is Grace Revere Osler Emeritus Professor of Surgery at Jefferson Medical College, and he also serves as university historian.

Charles M. Norris, MD, recently received a special award for "distinguished service in laryngology" from the International Federation of Otolaryngological Societies. Dr. Norris is clinical professor of laryngology and broncheosophagology at Temple University School of Medicine. He directs the Chevalier Jackson Clinic, a treatment facility for patients with cancer of the larynx.

Loretta P. Finnegan, MD, presented a paper on "Narcotics, Pregnancy, and Newborns," at the Fourth World Congress of Biological Psychiatry, held in Philadelphia. Dr. Finnegan is professor of pediatrics and associate professor of psychiatry and human behavior at Jefferson Medical College of Thomas Jefferson University. She also directs Jefferson's Family Center Program, which offers obstetrical, psychosocial, addictive, and pediatric care to women dependent on drugs.

Luis Schut, MD, Philadelphia, recently was appointed president elect of the International Society for Pediatric Neurosurgery. He is director of neurosurgery at the Children's Hospital of Philadelphia and professor of neurosurgery in pediatrics at the University of Pennsylvania School of Medicine.

Arthur Gershkoff, MD, has been elected president of the medical staff of Magee Rehabilitation Hospital, Philadelphia. **Christopher Formal, MD,** was elected vice president, and **Beryl Lawn, MD,** will serve as secretary.

Sarah S. Long, MD, has been appointed to membership on the Part II Pediatrics Test Committee of the National Board of Medical Examiners. Dr. Long is chief of the section of infectious diseases at St. Christopher's Hospital for Children. She is a member of the Society of Pediatrics Research, and she serves on the editorial board of the journal *Pediatrics.*

Two physicians received awards at Eye and Ear Hospital of Pittsburgh's Ophthalmology Department Alumni Dinner. **Gary Weinstein, MD,** was given the Outstanding Teaching Award for his contributions to the hospital's residency program. Residents also presented **Jay G. Linn, MD,** with a Distinguished Service Award for his many years of teaching at the hospital.

Thomas V. Sedlacek, MD, Philadelphia, is the 10th recipient of Pennsylvania Hospital's Clarence C. Briscoe Award. Dr. Sedlacek is chief of gynecologic oncology at the hospital and associate professor of obstetrics and gynecology at University of Pennsylvania School of Medicine. The Briscoe Award was established by **Harvey E. Duchin, MD,** and **Sandra Duchin, MD,** to honor a practitioner of obstetrics and gynecology who displays high ethical and medical standards.

Charles Poe Craig, MD, has been named chairman of the department of medicine at Albert Einstein Medical Center's Mt. Sinai-Daroff Division in south Philadelphia. Dr. Craig previously served as professor of medicine at University of South Florida College of Medicine, Tampa, where he established a teaching program in infectious and tropical diseases. In his new position at Albert Einstein Medical Center, Dr. Craig will oversee the development of a new residency program in internal medicine.

The family of a father and son team of plastic surgeons at Albert Einstein Medical Center's Northern Division is sponsoring an annual lectureship to inform physicians about current developments in their field. The Manstein Family Foundation was established by **George Manstein, MD,** Elkins Park; his wife Marield, and sons **Carl Manstein, MD,** and **Rick Manstein, MD.** Drs. George and Carl Manstein are attending physicians in ambulatory surgery at the medical center, and Dr. Rick Manstein recently joined Northern's staff. The premiere lecture featured **Peter Randall, MD,** professor and chief of the division of plastic surgery at the hospital of the University of Pennsylvania.

Steven J. Davidson, MD, Philadelphia, recently took office as president of the University Association for Emergency Medicine (UAEM). Dr. Davidson is associate professor of emergency medicine and surgery at the Medical College of Pennsylvania. UAEM is an academic organization that sponsors research, lectures, and seminars on emergency medicine.

A Hahnemann University research team made up of members from the university's departments of neurosurgery, neurology, pathology, and physiology and biophysics, has received the 1985 Volvo Award recognizing outstanding work in researching injuries to the central nervous system. **Perry Black, MD,** professor and chairman of the department of neurosurgery, accepted the award at the 8th International Congress of Neurological Surgeons in Toronto. Hahnemann's winning manuscript, "Experimental Studies in Spinal Cord Injury: Standardization of Two Injury Models," is part of an ongoing program to develop a standard model of spinal cord injury and to experiment with new treatments in the laboratory. Other physicians participating in the project are: **Viraf Cooper, MD; Alan Mechanic, MD; Ivan Damjanov, MD; Sidney D. Finkelstein, MD;** and **Martin Feldman, MD.**

Directory corrections

The August issue of PENNSYLVANIA MEDICINE, the membership directory issue, should be corrected as follows:

Specialty corrections:

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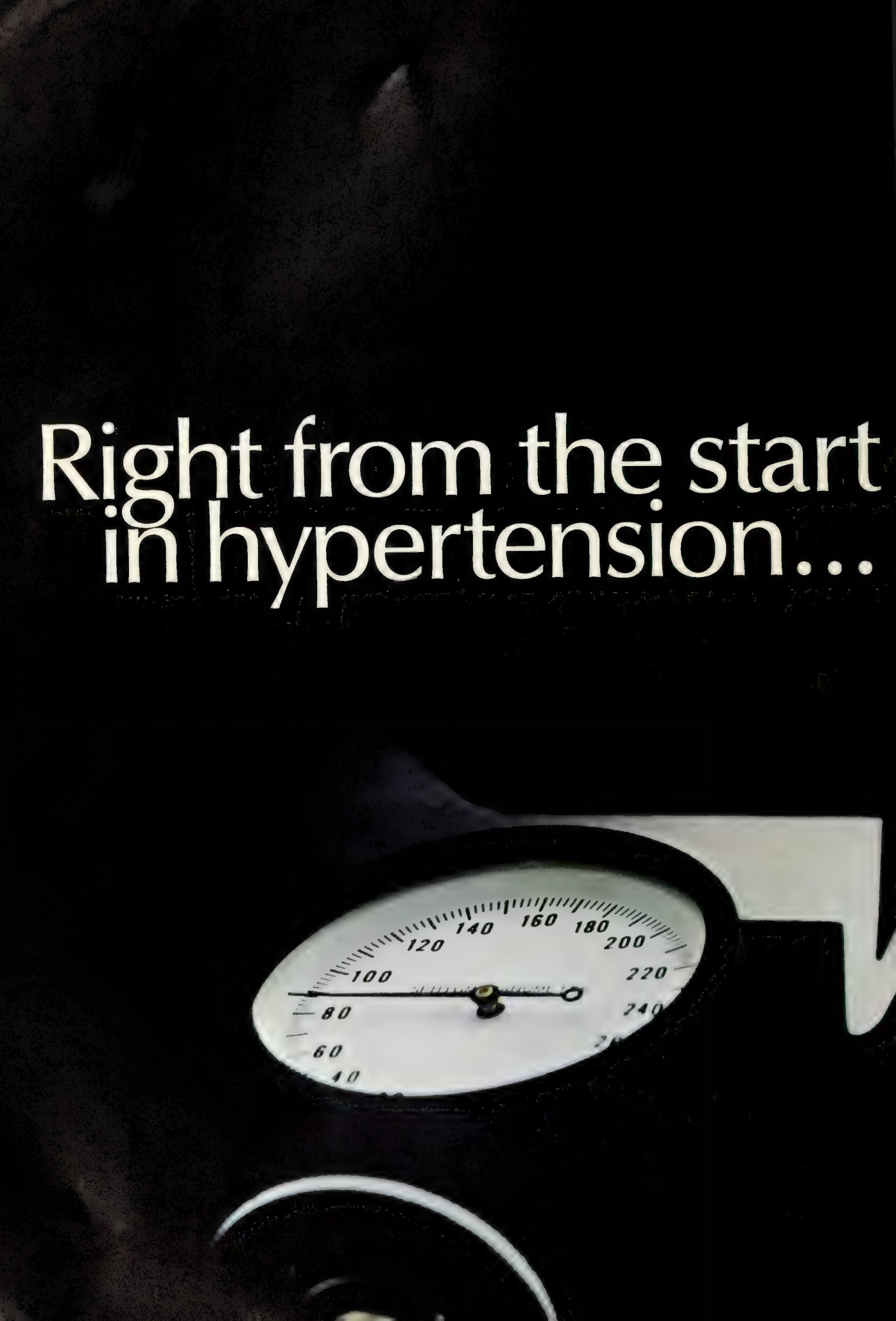

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The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

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Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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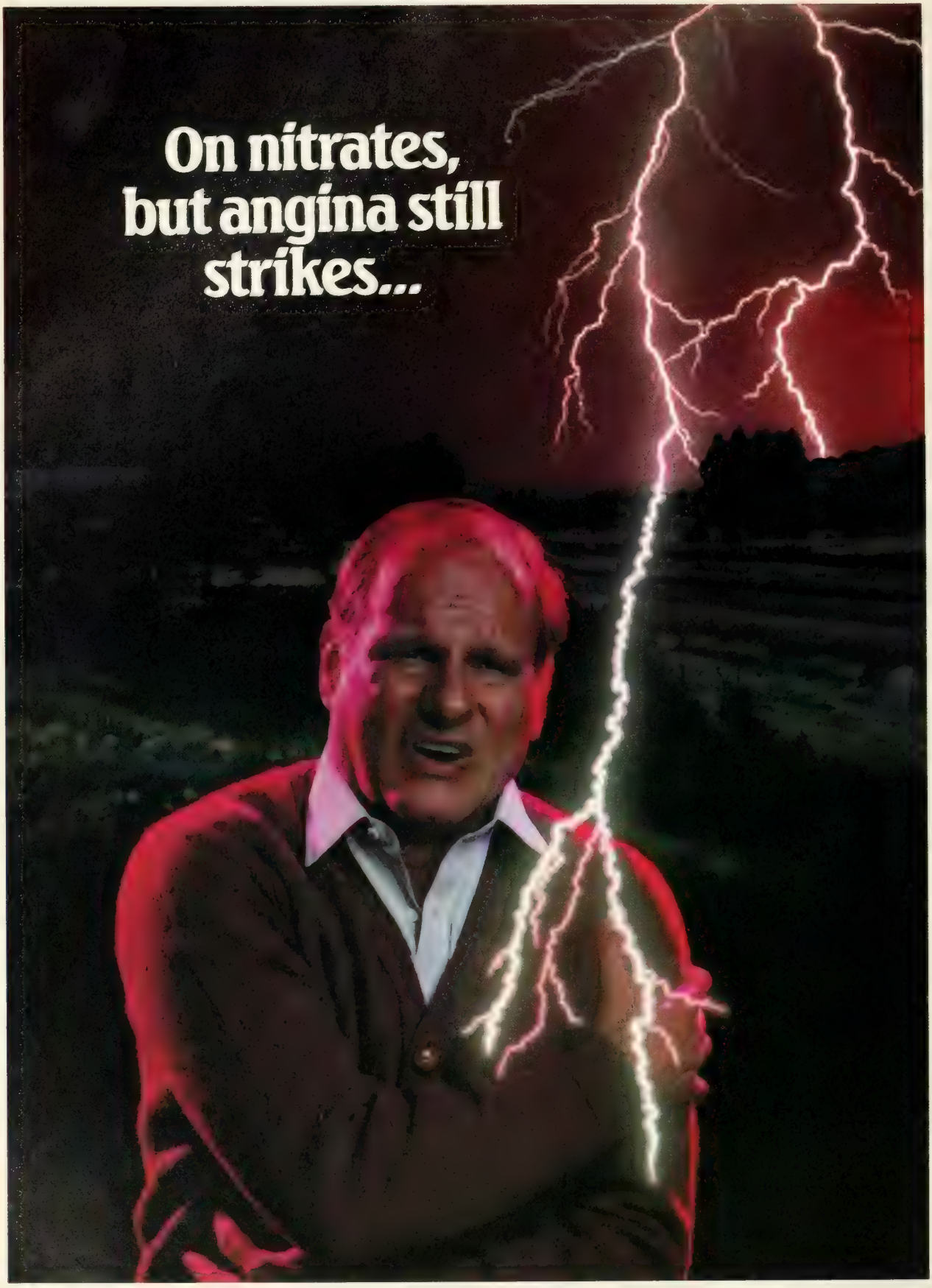
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Cardiovascular contra-dications to the use of ptin are similar to those beta blockers: severe t ventricular dysfunction, potension (systolic pres-re <90 mm Hg) or cardio-nic shock, sick sinus syndrome no artificial pacemaker is present) d second- or third-degree AV block.

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Please see brief summary on following page.

ISOPTIN®
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80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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Wednesday, November 6, 1985
Physiologic Pacemakers
Moderator: Gary J. Anderson, MD
3:00 p.m.

Case Presentation: Bradyarrhythmias—*Theodore J. Waller, M.D.*
Discussion, Including Indications for Pacing—*Allan M. Greenspan, M.D.*
Case Presentation: Pacemaker Syndrome—*Theodore J. Waller, M.D.*
Discussion, Including Pathophysiology and Results of Physiologic Pacing—*Steven P. Kutalek, M.D.*
Questions and Answers—*The Audience*

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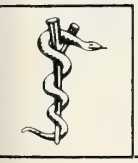

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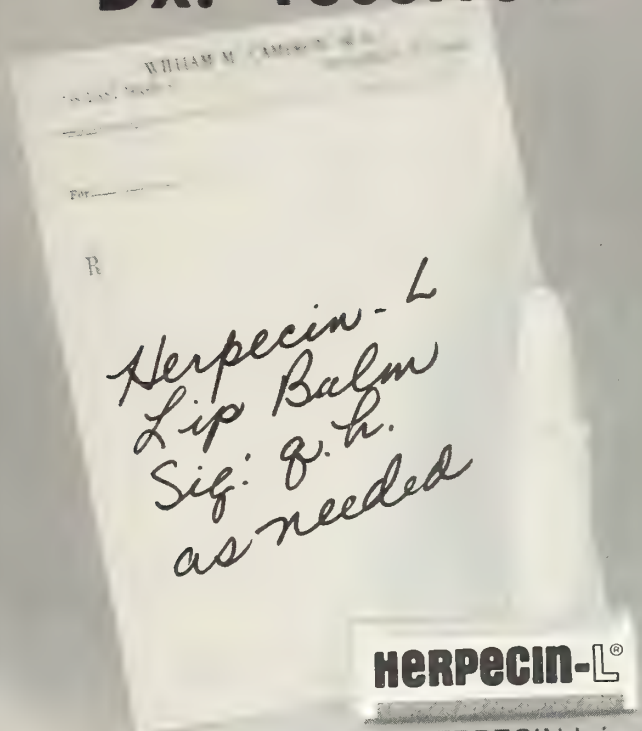

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Physician seeking practice in internal medicine. Prefers solo, partnership, single specialty group, or multi specialty group opportunity. Will be Board eligible in internal medicine 7/86. Prefers community of 5,000 or greater. Respond to PMS Physician Placement Service, Department NRM-0286-IM37, 20 Erford Road, Lemoyne, PA 17043.

Physician seeks position in neurology, desiring a partnership or single specialty group opportunity. Will be Board eligible in neurology 7/86. Prefers community of 10,000 or greater. Respond to PMS Physician Placement Service, Department NRN-0286-NR02, 20 Erford Road, Lemoyne, PA 17043.

Physician seeks opportunity in general practice/family practice/urgent care and emergency medicine. Prefers institutional position in a suburb around Philadelphia. Has a PhD in biochemistry; has done research in cancer, HBP, endocrinology. Respond to PMS Physician Placement Service, Department NPM-0286-GP06, 20 Erford Road, Lemoyne, PA 17043.

Physician specializing in internal medicine desires partnership, single specialty group, multi-specialty group position. Will be Board eligible in internal medicine 7/86. Prefers community of 5,000 or greater. Special qualifications/interests include decision analysis, personal computing, and computer programming. Respond to PMS Physician Placement Service, Department NRN-0486-IM41, 20 Erford Road, Lemoyne, PA 17043.

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Practices for sale — Allergy, suburban Philadelphia; Dermatology, Connecticut; Dermatology, Philadelphia. For more information send CV to: Health Care Personnel Consulting, Inc., 400 GSB Building One Belmont Avenue, Bala Cynwyd, PA 19004; (215) 667-8630.

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Hewlett-Packard phased array two-dimensional echocardiograph with strip writer (recorder) for sale. Purchased October 1, 1981. "Upgradable" to current Series "F" by Hewlett-Packard for approximately $12,000.00. Machine is in good working order but should be upgraded. Selling price can be negotiated. Call (412) 963-9328 evenings only.

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Diabetes Day Update — Wednesday, October 2, 1985, at the Sheraton Inn — Shenango, West Middlesex, PA. Sponsored by the Greenville Hospital, Greenville, PA and The Mahoning Shenango Area Health Education Network, Youngstown, OH. Program is directed toward primary care physicians, nurses, and allied health personnel interested in diabetes care. Credits: 7½ Category I hours. Registration: $50.00 physicians; $30.00 nurses and allied health personnel. For information call: (412) 588-9602.

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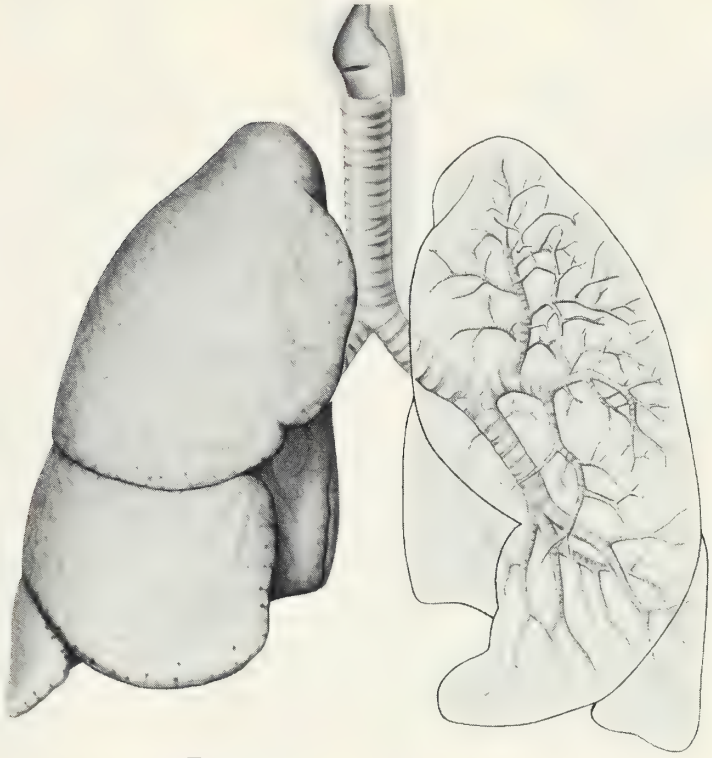

Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, H. influenzae, S. pneumoniae, S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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special feature

Computers, medical data, and statistics

Charles Heisterkamp III, MD, FACS

A donation to the PMS Trust can solve the puzzle, open the door, point the right way. Read on!

"The computer is incredibly fast, accurate, and stupid. Man is unbelievably slow, inaccurate, and brilliant. The marriage of the two is a force beyond calculation."

These words, spoken many years ago by Leo Cherne are, perhaps, even more true today. Yet what makes the marriage a force beyond calculation? And will the force be good or bad?

If a man puts inaccurate data into the fast computer, then the results will be less than beneficial. If the computer is given inaccurate instructions, it will generate "stupid" results. The union will not be a marriage "conceived in heaven."

Today, there is an increasing reliance on the computer in all areas of medicine. The cost-quality crunch makes it increasingly important that accurate information is available. The following is a paper written several years ago and presented to the board of the Pennsylvania Southcentral PSRO. Unfortunately, little good resulted, and there was a continued use of inaccurate data. The effect that the PSRO exerted on medical care was minimal. With the advent of DRGs and a significant restructuring of medical care delivery, the patient will become increasingly vulnerable to the effects of a poor marriage of man and computer. As with the words of Leo Cherne, this message is as applicable today as when first written.

Statistics and the PSRO

If any area of the medical system might be expected to provide a plethora of data on the cost and utilization of surgery it should be the Medicaid program, which provides joint federal-state assistance for the needy. Recently, the Subcommittee on Oversight and Investigations of the House Interstate and Foreign Commerce Committee concluded, "HEW is not able to provide elementary data indicating the costs and kinds of surgery being paid for under Medicaid. . . " Within the Southcentral Pennsylvania Professional Standards Review Organization, my experience on the Data Committee indicates the same problem. In this paper, I will highlight some of the major problems, review briefly the statistical considerations, and suggest possible solutions.

First, one must recognize that a significant problem exists and, once recognizing and accepting that fact, one must agree a solution is possible and feasible. I am continually dismayed by the thought expressed by some members that any numbers are better than none and by the thought that the problem is so immense no one, especially at a regional level, can solve the problem. As a later example will show, all numbers are not necessarily good (i.e., valid) and more numbers are not necessarily better (i.e. more accurate). Further, while I agree that implementation of a solution may require acceptance and promulgation at a national level, it is both a right and a responsibility of a local organization not to proceed with "mandated" techniques which are clearly inadequate and it is also a duty to devise and suggest to others the appropriate methods for a solution to the problems.

Since (in theory, at least) the elements involved (patients, diagnoses, treatments, etc.) are capable of being defined, categorized, and measured, statistical methods are appropriate for design and evaluation of the method and technique to be used in solving problems. Therefore, one must approach the attempt at solution with some understanding of statistics.

"You can prove anything with numbers" is a common expression. I suggest that that comment is one born of ignorance and the unhappy experience of having been misled and duped by clever manipulators of numbers. How can data be misleading?

1. Arithmetical errors.
2. False percentages.
3. Fictitious precision.
4. Misleading presentation.
5. Incomplete data.
6. Faulty comparisons.
7. Improper sampling.
8. Failure to allow for the effect of chance.

Some of these problems are readily understood and prevented. Mathematical errors—these should be prevented by careful techniques and uncovered by appropriate cross-checks. But some are the result of attempts to use the same values, stated in different ways, to impress, and hence, "prove" a point.

False percentages — For example, "This problem occurs 1000% more often with Dr. A than Dr. B." But 1000% is equivalent to saying 11 times—not quite so impressive.

Misleading presentation — an infection rate of 1 percent of all hospital admissions may represent the same patients having hernia repairs with a 10 percent infection rate!

Incomplete data — most of us read

Dr. Heisterkamp is a member of the Society's Council on Economics and chairman of the subcommittee on computers.

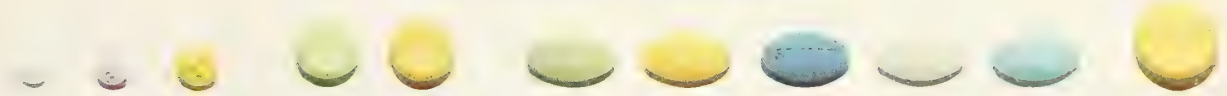
Angina comes in many forms...

So does

SORBITRATE®

(ISOSORBIDE DINITRATE)

Unsurpassed flexibility in nitrate therapy.



2.5 mg 5 mg 10 mg — Sublingual Tablets

5 mg 10 mg — Chewable Tablets

5 mg 10 mg 20 mg 30 mg 40 mg — Oral "Swallow" Tablets

40 mg — Sustained Action "Swallow" Tablets

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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

STUART PHARMACEUTICALS
Division of ICI Americas Inc.
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STR-2282

SEVENTH ANNUAL MINIRESIDENCY IN OCCUPATIONAL MEDICINE

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
RUTGERS MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY 08854

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April 1-18, 1986/14 weekdays/8:30 a.m.-4:30 p.m., 6 evening classes/6:30-8:30 p.m.

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the recent statistics that the risk of being killed in an automobile accident while a passenger in a small car is 5½ times greater than when in a large car. Omitted is the fact that small cars are not involved in accidents as frequently as large cars. The overall risk is almost identical.

Faulty comparisons — in the Spanish American war the death rate in the U.S. Navy was 9/1,000. For civilians in New York City, the death rate was 16/1,000. Obviously, to be safe, join the Navy. No!!! The Navy was composed of young, healthy people while the city population included the elderly, the chronically ill, etc. The groups were not comparable.

Allowing for Chance — first, realize that there is absolute truth and probable truth. Absolute truth must be implied from the premises defined for the situation. For example, if one selects three people at random from a population of 50 men and 50 women, one *knows* that at least two of the people will be of the same sex. This is *absolutely* true. But in many cases, the conclusion reached will be based on incomplete data. Using the laws of chance, one can determine the probability the conclusion is correct (true).

There are four Laws of Probability.

First Law - The Proportionate Law — If there can be more than one result of an action, and all results have an equal chance of occurring, the *probability* of any one occurring in a *single* trial, is in the same proportion as that result bears to all possible results.

Second Law - The Law of Averages — Given the same premises as above, in a number of trials, the results observed will generally vary to an extent from the inherent proportions, but as the number of trials increase, the extent of the variation will become progressively less.

Third Law - The Addition Law — Given the premises above, the *probability* of alternative results occurring in a single trial is the sum of the probabilities for the individual results.

Fourth Law - The Multiplication Law — The *probability* of any *combination* of results in two or more independent trials is the product of the individual probabilities.

What is *real?* What is *apparition?* If I told you that I had a test that was 95% reliable in detecting a cancer occurring in 0.5% of the population, would you approve it for use as a universal screening study? One's initial impression from the figures would be to say "yes". But what is the *probability* that a patient with a *positive* test HAS cancer? Using the multiplication law, 0.005 (proportion of people with cancer) × 0.95 (test reliability) = 0.00475. But we must allow for the possibility that a person without cancer will have a positive test. 100-.5=99.5%-.995. And 5%=0.05 of the non-cancer patients may have a positive test. 0.995 × 0.05 = 0.04975. The *probability* of any person (with or without cancer) having a positive test is the *sum* or 0.05450. The probability that any given positive test is due to cancer is the probability of cancer plus a positive test occurring together divided by (in proportion to) the probability of a positive test for the entire group. 0.00475 / 0.05450 = 0.09!!! Thus, of 100 patients with a positive test, only 9 would have cancer. No really such a good test after all.

If statistics are to be useful in evaluating the data, the data must be good (i.e. accurate and reliable). The problems of data collection are recognized, but seldom are alternative approaches considered which might produce more accurate and more reliable data. To quote one text, "Studies that compare alternative methods and procedures within the framework of well-designed and randomized experiments have been exceedingly important for learning about the effectiveness of various procedures and in comparing their costs and accuracies . . ." (p. 282 "Statistics: A Guide to the Unknown" edited by Judith M. Tanur. Holden-Day, New York, 1972). For example, a study done during the 1950 U.S. Census sought to determine the effect of the enumerators (the people who collect the data) on the data collected. The effect on *difficult* items such as income, education, and employment status was surprising. The study showed that a *complete* census had as much variability (because of enumerator effect) as a 25 percent sample with no enumerator effect. What were some solutions? Spend time and money training better enumerators. Logical. But not as good as a better questionnaire given directly to the respondent to fill in. The second method proved better. More reliable data, lower cost, and more rapid compilation of the census were the results of using the second method.

Using statistical methods, one can predetermine how much data must be collected to obtain a pre-determined degree of significance or non-significance. Techniques such as sequential design, originally described by Abraham Wald in the early 1940s, permit plotting the data as it is acquired and obtaining statistically reliable conclusions from the minimum amount of data.

In order to use these methods, one must define the objective(s) of the PSRO program. Are we concerned with quality of care? If so, what are the parameters? Is cost the concern? If so, measured in absolute terms or against some scale of cost versus benefit? Even here, the proper use of statistical methodology may serve to demonstrate an unknown factor's presence. Much as the astronomer may predict the presence of an unknown celestial body by its effect upon known bodies, so might one postulate the existence of a factor effecting health care.

This paper suggests the methods and approaches necessary to obtain meaningful and reliable health care data. H.G. Wells said, "Statistical thinking will one day be as necessary for efficient citizenship as the ability to read and write." And lest you feel that in the jungle you will be safe, consider the problem of the stranger, pursued by the tiger, going along the trail which suddenly forks, one path going to the Liars' Village (who by the way are cannibals and otherwise generally nasty to strangers) and one path going to the Truthtellers' Village (who will shower the stranger with gifts and riches beyond belief and the answers to the PSRO dilemma). Given that Truthtellers always tell the truth, and Liars always lie, you, the stranger, are confronted at the fork with the fierce native (maybe a goodie, maybe a baddie). You have the chance to ask *one* question before you must choose a path. What is your question?

"The computer is incredibly fast, accurate, and stupid. Man is unbelievably slow, inaccurate, and brilliant. The marriage of the two is a force beyond calculation."

The application of the principles enumerated in the paper will make the marriage truly a positive force.

For those of you who don't know which question to ask, and want to know, a $10 donation to the Pennsylvania Medical Society Educational and Scientific Trust will entitle you to the answer. □

in my opinion

For him, the choice is easy

Abraham J. Twerski, MD

What percent of health professionals—doctors, nurses, dentists—have alcohol or drug problems? Two percent? Six percent? Eleven percent?

The precise number is really not crucial. It is a fact that alcoholism and chemical dependency are the most nondiscriminating equal opportunity-destroyers around. The particular role of the health professional in matters of life and death is such that any compromise of mental activity is unacceptable.

Professional organizations have taken measures to promote early case finding and referral to treatment resources. These efforts have been most rewarding.

One obstacle occurs, however, when a hospital refuses or is reluctant to permit a recovered physician or nurse to resume clinical duties. Such a policy, most often unwritten, can have only one effect: to encourage the cover-up of a chemical dependency problem until it is so flagrant that concealment is no longer feasible. This not only terminates careers, but along the way, may cause patients to suffer.

What should be done? Hospitals should realize that this problem is a fact of life and will not go away if they bury their heads in the sand. Policies should be adopted, implemented, and publicized that persons who are successfully recovered, and whose function can be monitored when necessary, can return to their professional duties.

Dr. Twerski is clinical director of Gateway Rehabilitation Center, in Aliquippa. A past president of the Allegheny County Medical Society, he has played a leading role in programs for impaired physicians, including the PMS Committee on the Impaired Physician. He is the author of several books and numerous articles for the professional and lay press. This essay is reprinted from The Bulletin, *publication of the Allegheny County Medical Society.*

Suppose the prevalence of alcoholism among physicians is only one out of a hundred. If that one happens to be *my* surgeon, I may be in trouble.

If I am lying on the operating table, and the operating surgeon has steady hands at 8 a.m., it may be for one of two reasons. Either his hands are naturally steady, which is just fine, or he is that one out of a hundred who drank heavily the night before, and whose hands are steady because he shot up with Demerol or took a barbituate before coming into the OR to subdue his tremors, which is not fine at all. In the latter case, his hands are steady at the price of his mind being obtunded.

I know not what course others may take, but as for me, give me a surgeon who attends AA meetings regularly several nights a week. I will then know that the steadiness of his hands does not come at the price of diminished mental acuity, and my mind will be very much at ease. □

Balint Groups in family practice

Fred B. Rogers, M D

Psychotherapy, according to the Hungarian-born British psychoanalyst Michael Balint, is a process for changing behavior in a special kind of learning situation. Through this process two or more people attempt to correct the effects of disruptive experiences or of certain deficiencies in learning. The principal goal of psychotherapy, therefore, is to modify personal reactions to problem situations. This problem-solving attitude forms the basis of what are called Balint Groups where psychological aspects of patient-physician interaction are discussed by family doctors and psychiatrists.[1] Such Balint-type discussions are used in the teaching of family practice residents at, among other places, the Temple University-affiliated Rolling Hill Hospital and Diagnostic Center in Elkins Park.

Formation of the Royal College of General Practitioners in 1953 was largely responsible for a revitalization of family medicine in Great Britain. Among its innovative postgraduate efforts was approval of the research-cum-training seminars then conducted by Michael Balint and his wife Enid (a psychiatric social worker) at the Tavistock Clinic and Institute of Human Relations in London.[2] Following several preliminary articles on the group dynamics of training and on the doctor-patient relationship, Balint's historic book, *The Doctor, His Patient and the Illness*, was published in 1957; a second edition appeared seven years later and it was issued in paperback in 1968.[3] This classic volume had a stimulating effect on general practitioners around the world, for it offered them new hope and challenge with its emphasis upon 'whole-person medicine.'

Dr. Rogers is professor of family practice and community health at Temple University School of Medicine, Philadelphia.

In 1956, Dr. Balint became a visiting professor of psychiatry at the University of Cincinnati College of Medicine. Also in that year, a collection of his essays on humanistic psychiatry, *Problems of Human Pleasure and Behavior*, was published in New York.[4] (This book was issued in paperback in 1973.) Balint gave many lectures in the United States, including the 1964 Thomas M. French Lecture at the Chicago Institute for Psychoanalysis entitled "Psychoanalysis and Medical Practice." Subsequently he journeyed to Australia and elsewhere to present talks on related topics. He was planning a return tour of the United States at the time of his death on the last day of 1970 at age seventy-four. In a memorial tribute Balint's colleague Dr. John D. Sutherland

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said: "A few years ago, a general practitioner remarked to me that Balint had changed the face of British medicine. The comment was not made lightly, and I believe that many family doctors would endorse its claim."[5] Numerous other physicians have praised Balint's teachings, which brought psychoanalytic insights into the family circle.

In his writings about the doctor-patient relationship, Michael Balint emphasized the nature and uses of empathy. The physician, he noted, should cultivate a capacity for participating in another's feelings or ideas. This responsibility he termed the doctor's therapeutic function.[6] Since he is himself part of the prescription, his own person being a therapeutic agent, the doctor serves an apostolic role in cheering and curing the patient. In a confidential interview there is no intermediary between his client and himself, so the therapist must have purity of motive when facilitating change of thought or behavior. To this end Balint wrote: "I know that these ideas throw a heavy and alarming responsibility on all of us—general practitioners, specialists, psychoanalysts alike—but . . . I firmly believe that by becoming more aware of our roles in the patient-doctor relationship, . . . our therapeutic efficiency will grow apace."[7]

The Balint Group, a seminar method of making a long-term study of patients' problems and the physician's reaction to them, has continued to evolve since its formative years at London's Tavistock Clinic. It is now a world-wide instructional process among family physicians. Several international Balint conferences (the first such biennial meeting was held in 1972) have convened to implement Balint training.[8] In North America, the Society of Teachers of Family Medicine has an informal section of devotees which meets during its annual session.[9] These meetings all enhance the aim of Michael Balint who wrote in 1966: "Let us hope that if we can train our general practitioners to become sensitive observers and reliable reporters a great step will be made in understanding both the personality of the individual and the structure of that most important unit, the family."[10] □

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Our forthcoming uncomfortable destiny

J. Mostyn Davis, MD

Please don't get me wrong. I really enjoy the practice of medicine. If I could not be a physician, I have no idea what my occupation would be. My happy lot is to be one of those persons who gets paid for doing what he loves to do! My practice has now lasted long enough that I see many predictions about the downfall of medicine in America pass away. By the same token, most of the overly optimistic claims of what medicine will do in the next five years, also have disappeared. As time goes by, my tendency has been to accept all predictions with a grain of salt and considerable skepticism.

But now, as I look at where we are as a profession, and at the monumental forces bringing pressure to bear on the entire medical establishment, it does appear we may safely predict some important and far reaching alterations in what has come to be called the "health care delivery system." I personally do not deliver any health; all I do is care for people who are ill. The portents are unsettling. Since 1965 and the Federal Open-Ended Public Commitment to Subsidize Medicine for the Elderly and Poor, a severe crisis has slowly been building. It now appears the time to "pay Peter" has arrived. Medicine today faces the danger of being beset from before by the burgeoning array of rapidly growing "investor-owned," i.e. for profit, corporations. It is estimated that they own or manage 15 percent of the general hospitals and nearly 80 percent of the nursing homes in this country.

The second besetting force is the government's push for "competition" between the various members of the medical profession. Michael Pollard, of the Federal Trade Commission, writing in the *JAMA* (V 249, No. 14, pp. 1860-2), said that the competition route would be better than the regulation pathway. "Health care regulation," he said, "is a complicated web of publicly and privately imposed controls, most of which have strong constituencies that support their continued existence." A competitive health service market, he said, should create the economic incentives for physicians to design their own techniques to increase efficiency in the delivery of health care.

In the same issue of the *JAMA*, Dr. Eli Ginzberg agrees that the acceleration of costs must be moderated, but this should prove feasible through budgetary control and improved systems for reimbursement. He suggests we do not need a radical reform aimed at establishing a different set of controls which have not been widely tested and which would end up being centered on price rather than on quality. In addition to not being necessary, he says, "It is not desirable and may not even be feasible."

In automobile sales there are levels of standards. Some folks buy Volkswagons while others purchase Lincoln Continentals. It depends on your level of desire and your ability to purchase the vehicle. This is the rule with most purchases. You choose the level that you will be satisfied with and can afford. In medicine, physicians have ever struggled to maintain one level of care for everyone, Cadillac care! Have we come now to the point where decisions involving the level of care must be made? If so—who is to make those decisions? Not me! I still want *my* patients to get the best care that is available today! I am willing to stand up and be counted on that issue. The competition pathway that puts economy ahead of quality is not for me. □

Dr. Davis is a family physician in Danville and represents the Fourth District on the PMS Board of Trustees.

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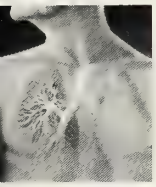

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WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

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Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

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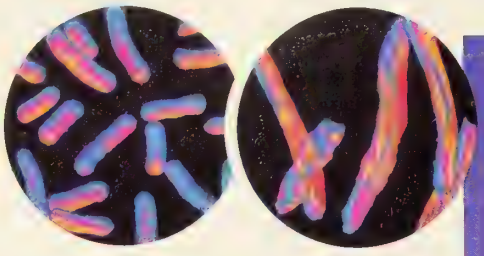

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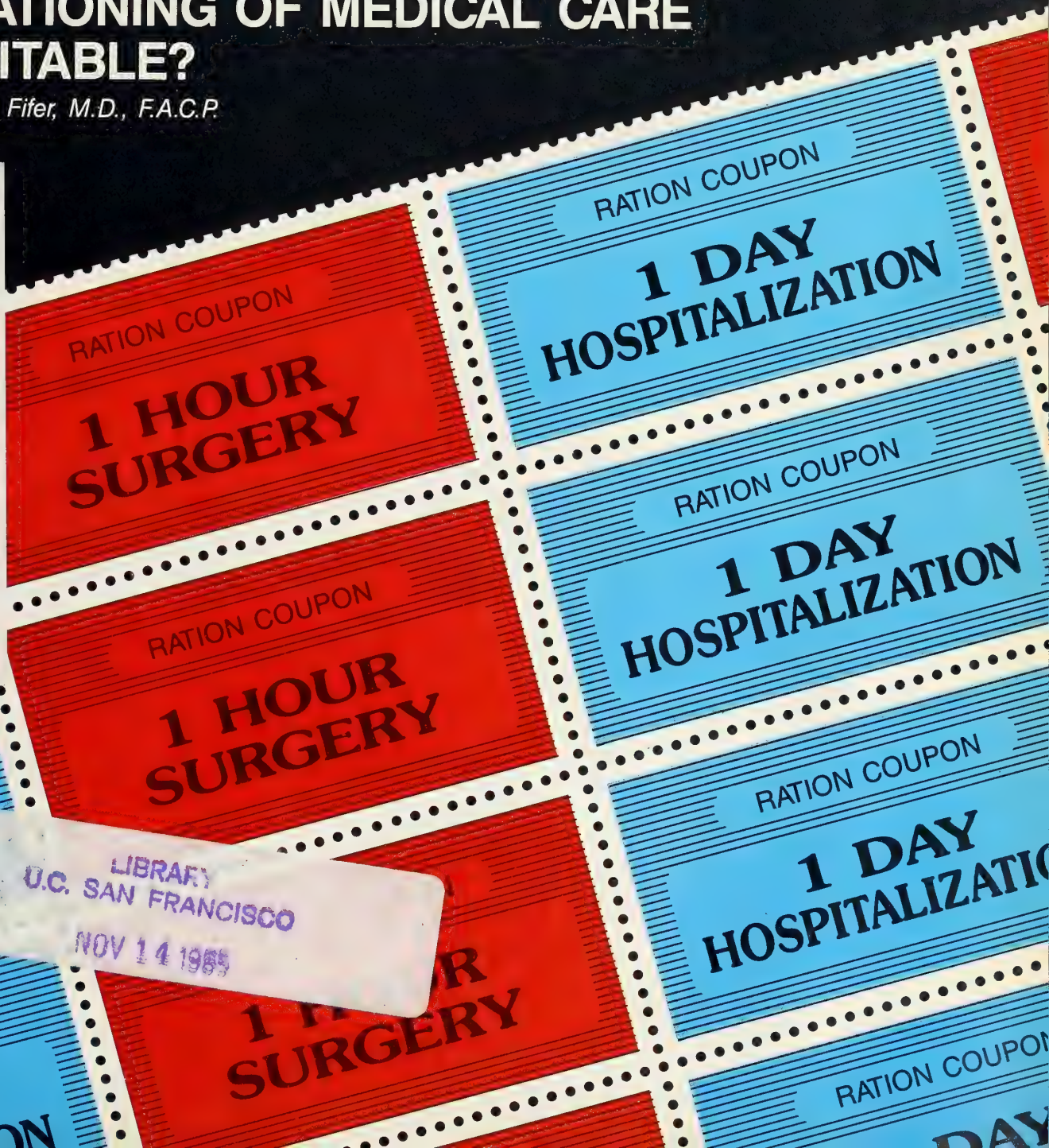
illiam R. Fifer, M.D., F.A.C.P.



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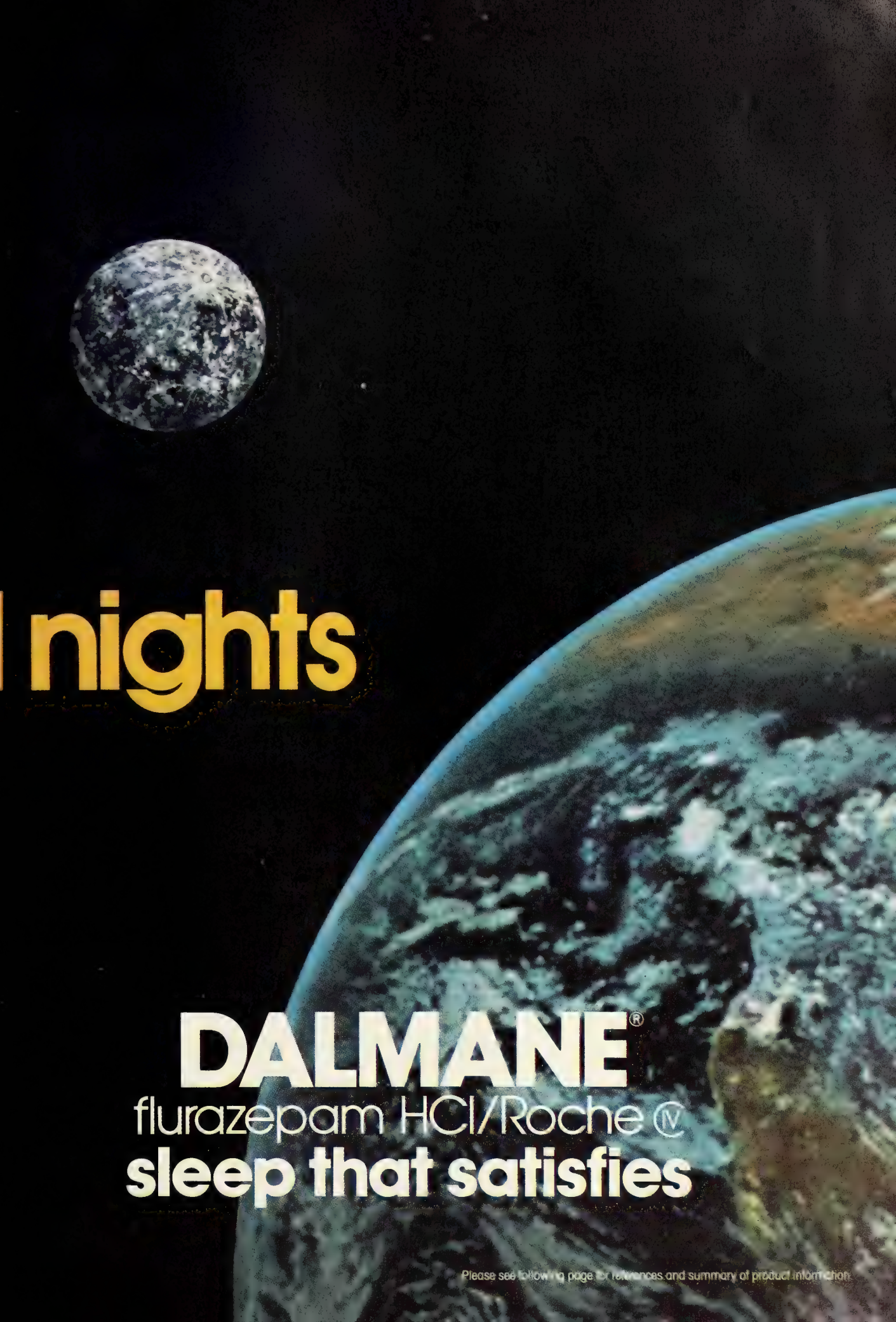
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving) Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage
Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia Consider potential additive effects with other hypnotics or CNS depressants Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity
Dosage: Individualize for maximum beneficial effect *Adults* 30 mg usual dosage, 15 mg may suffice in some patients. *Elderly or debilitated patients* 15 mg recommended initially until response is determined
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl

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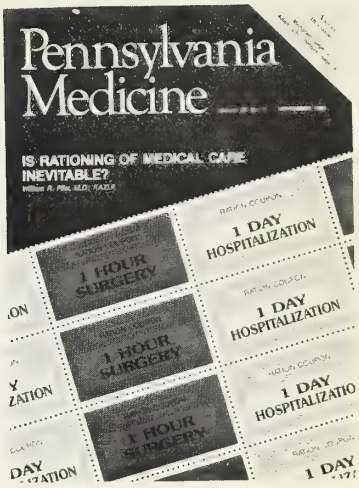

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Right from the start in hypertension...

Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

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For beta-1/beta-2 blockade

Once-daily INDERAL LA

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80 mg 120 mg 160 mg

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Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular. bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System. lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic. pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory. bronchospasm.

Hematologic. agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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BALANCED CALCIUM CHANNEL BLOCKADE!

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

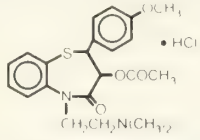
Please see full prescribing information on following page.

2/84

PROFESSIONAL USE INFORMATION

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

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SENATE SET TO CONSIDER MEDICAL PRACTICE ACT

The Senate Committee on Consumer Protection and Licensure, chaired by Senator Clarence Bell, introduced the Medical Practice Act of 1985 into the Senate on October 17. It contains significant changes from the 1975 Act, which has been under sunset review this year, along with the other "healing arts" acts. The PMS Task Force on the Medical Practice Act, chaired by Robert D. Reinecke, MD, of Philadelphia, drafted the initial version of the Act just introduced, and the Society's representatives have worked closely with the committee during its consideration of the proposal.

AMA INTERIM MEETING IN WASHINGTON, DC

PMS President R. William Alexander, MD, will chair Reference Committee D—Hospitals and Medical Facilities when the AMA House of Delegates meets in interim session December 8 to 11, 1985, in Washington, DC. Because of its proximity to Pennsylvania, the 1985 interim meeting presents an opportunity to the Commonwealth's physicians to observe a meeting of the AMA House of Delegates at first hand. The Sheraton Washington Hotel at Connecticut and Woodley Avenues, NW, is headquarters for the meeting.

MEDICARE FEE FREEZE EXTENDED TO NOV. 14

An extension of 45 days of the Medicare fee freeze was announced by a letter sent from the Health Care Financing Administration through Medicare carriers the week of October 14. The 45-day extension was passed as emergency legislation by Congress on September 30, the day the fee freeze was due to expire. The letter which all physicians should have received from the Medicare carriers announces that through November 14, 1985, physicians' charges will remain at the level of customary and prevailing charges which were in effect through September 30, 1985. The legislation does not change the recent participation choices made by physicians for the year beginning October 1, 1985. Those choices are in effect and binding during the 45-day period. Physicians who are currently participating in Medicare may increase their actual charges during this 45-day extension.

CONFIRMED RABIES CASES SET RECORD IN SEPTEMBER

Pennsylvania set a record for a monthly total of rabies cases in September. The Department of Health reported that the 68 confirmed cases made the highest monthly total since the late 1940s. The 68 cases brings this year's total to 281 through September 30. When the state broke a 37-year record with 384 cases in 1984, only 246 were recorded through September. Thirty of the state's 67 counties have now confirmed cases in 1985. Adams (72 cases) and Cumberland (52 cases) counties continue to lead the state count. The state health department offers consultative services to physicians who must evaluate the need for antirabies treatment for patients exposed to rabid animals. Telephone (717) 787-3350 for information.

MEDICARE COST ESCALATES FOR BENEFICIARIES JAN. 1

A billion dollar plus increase in Part A Medicare cost will be borne in 1986 by beneficiaries. The increase to $492, amounting to a 23 percent rise in Part A coinsurance and deductibles, is necessary to finance increased costs of hospital, nursing home, and home health services. Shorter lengths of stay in the hospital have caused a sharp increase in per day hospital costs, since fixed costs must be spread over fewer patient days in the hospital. Part B premiums will remain unchanged.

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editorial

The end of an era in medicine

Rugged individualism in medicine is dying. The era of the solo, fee-for-service practitioner is slowly giving way to other methods of heath care access. All evidence points to the demise of the traditional practice of medicine and to the parallel growth of group practices, HMOs, convenience clinics, and ancillary profit-making enterprises. There are those who predict that individual private practice on a fee-for-service basis is finished. Euripides' observation, "The best of seers is he who guesses well," and Yogi Berra's comment, "It's not over 'til it's over," both apply equally to the cottage industry.

Individual private practice of medicine does seem to be losing ground. In 1975, 54.2 percent of physicians were in solo practice compared with the 1983 figure of 48.9 percent. Practices with five or more physicians accounted for 16.8 percent in 1975 but rose to 22.7 percent in 1983. Some would argue that physicians have always practiced in groups by using standard patterns of referral and that the trend toward group practice is merely a formalization of those activities. While that is a possible explanation, it is likely that other, more pertinent factors are responsible for the shift.

Henry Sigerist noted, "Group medicine is a superior form of service. The best way to make full use of the present technology of medicine is to organize medical groups, teams that will practice in health centers. These must be close to the people, in industrial center, residential neighborhood, or farm." Sigerist, a leading medical historian of his time, died in March of 1957, before the trend toward group practice really began.

The more current reasons for the upsurge in group practice include longer residency training programs which reinforce group interaction, circumvention of the lean years and debts which accompany setting up a solo practice, and a quicker realization of profits to offset medical education debts. Group practices guarantee salaries, fringe benefits, retirement plans, and time off. They allow for specialization and permit scheduling of hours for the convenience of patients without undue strain on physicians. Finally, a large group with a good reputation can control a larger share of the patients in a given area.

Private practice also is likely to be affected by increasing physician supply. A number of studies have predicted an oversupply of physicians by 1990. Even though these predictions are controversial, the number of physicians has increased from about 233,000 in 1950 to about 487,000 in 1980. During this same period, the number of medical schools rose from 80 to 126. Increasing numbers of physicians and inequities in geographic and specialty distribution already have contributed to the creation of a competitive medical marketplace. Fairly common now is advertising for patients, first from the HMOs and more recently from physicians. Competition for larger portions of the patient market has produced specialization and even sub-specialization, convenience or walk-in clinics, the return of house calls, extended hours, and multiple specialized services. Physicians are reassuming many of the services that were provided by allied health personnel during the last decade.

No review of the status of private practice would be complete without mention of government programs and regulations that are causing and will continue to cause changes in the practice of medicine. When Congress adopted prospective payment for hospitalized patients under Medicare, it asked for a report by December 1984 on the possible application of prospective payment to physicians' fees. Some form of control, perhaps at first only for Medicare patients, can be expected on physicians' fees.

In another effort to hold down medical care costs, the government has encouraged the development of HMOs. HMOs operate on the premise that capitation payments will limit the medical services provided and keep patients out of the hospital. HMOs have grown in number from 33 in 1970 to 269 in 1985—and the government has provided much of the seed money for their foundation.

Government also inspired peer review vith the old Professional Standards Re-view Organizations (PSROs), which ıave evolved into the present day PROs. The PROs do pre-admission cer-ification for Medicare patients as well ıs concurrent and retrospective chart eview.

Because of the availability of public lollars in health care, the business com-nunity has expanded into the field of nedicine. A number of for-profit chains of hospitals are in the marketplace and ıave claimed a share of paying or in-ured patients. However, their disinter-st in the not-so-well-off patients, if the present trend continues, inevitably will ead to a two or more tiered health care ystem.

Last, but most certainly not the mallest concern to private practition-rs, is medical professional liability in-urance. Unlike the mid-1970s, insur-ınce can usually be obtained but the ost is very high. More claims are being nitiated. Before 1976, there were 2.9 laims annually per 100 physicians; rom 1976-1981 that number jumped to .2. Awards, both those of average ımounts and those over one million dol-ars, are on the increase. Insurance com-panies have served notice that premi-ıms, which have been kept artificially ow by state insurance departments and he unusually good return on invest-nents in recent years, will go up.

William J. Mayo, one of the pioneers of clinic medicine, predicted the end of 'solo" practice when he said, "The best nterest of the patient is the only inter-st to be considered, and in order that he sick may have the benefit of advanc-ng knowledge, union of forces is neces-ary to develop medicine as a coopera-ive science; the clinician, the specialist, nd the laboratory workers uniting for he good of the patient . . . The people vill demand, the medical profession nust supply, adequate means for the proper care of patients, which means hat individualism in medicine can no onger exist."

However we eventually practice med-cine, it is imperative that the social re-ponsibility of the profession be main-ained. Physicians have by tradition raded on their knowledge, time, and kill. It is essential that our future bot-om line include these as part of our so-ial responsibility.

David A. Smith, MD
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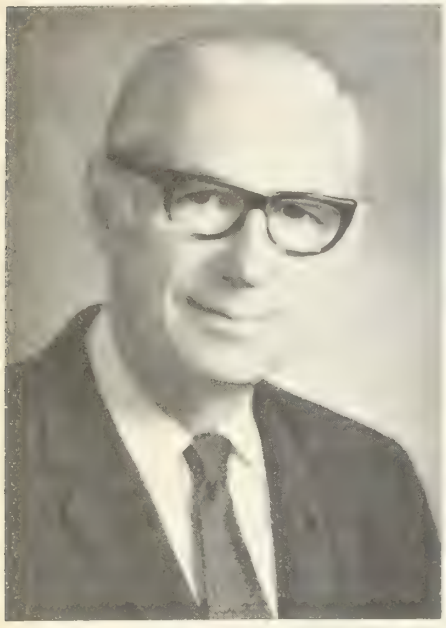
newsfronts

Internists give Dr. Pressman highest honor



Robert S. Pressman, MD, Philadelphia, chairman of the Board of Trustees of the Pennsylvania Medical Society, received the American Society of Internal Medicine's (ASIM) top honor, the Distinguished Internist of the Year Award, on October 10. The award was presented at the society's annual meeting at the Hyatt Regency on Capitol Hill, Washington, DC. It was given for contributions to ASIM at the national, state, and local levels.

A Board certified internist, Dr. Pressman is chairman of the investment committee of ASIM. He is a past president of the Pennsylvania Society of Internal Medicine (PSIM), as well as the Philadelphia region of PSIM.

In addition to his involvement with these groups, Dr. Pressman has been active in a number of other organizations. He is a past president of Philadelphia County Medical Society and the Colleg of Physicians of Philadelphia. He prev ously was chairman of the PMS Inte specialty Committee.

After graduating from Temple Un versity School of Medicine, Dr. Pres man completed his internship and res dency at Jewish Hospital, Philadelphi He has served on the staffs of Alber Einstein Medical Center, and Germa town and Rolling Hill Hospitals.

PMS congratulates Dr. Pressman

On behalf of your colleagues on the Board of Trustees, the staff, and all of the mem bers of the Pennsylvania Medical Society, I send you these words of congratulations an best wishes. We want you to know of our support as you are honored by your peer nationwide as "Distinguished Internist of the Year."

Few physicians have served their patients and their profession with such distinction a have you, Bob Pressman. A skilled and respected clinician among your peers, you ar cherished by your patients as a compassionate and concerned physician. But your sens of obligation to the profession you love has demanded that you serve medicine as well a your patients. And that commitment to the profession has resulted in a record of servic which leads brightly to the moment you now enjoy . . . recognition for exemplar achievement.

Others have and will speak to your tireless efforts for your specialty. Our words ar reserved for the countless hours of hard work and thoughtful leadership which you hav given organized medicine in Pennsylvania, particularly at the state level. As chairman c the Board of Trustees of the Pennsylvania Medical Society you have provided patience wisdom, and insight in leading the Board through these past three perilous years.

D. Ernest Witt, MD
President, Pennsylvania Medical Society

Show focuses on women in medicine

Send Us a Lady Physician: Women Doctors in America, 1835-1920 is a multi-media traveling exhibition, funded in part by the National Endowment for the Humanities, currently on display at the Historical Society of Pennsylvania, Philadelphia. The show, which will be in Philadelphia until January, 1986, documents the history of women's entry into the American medical profession. After its opening in Philadelphia, the exhibition will be transported around the country for at least three years.

The Medical College of Pennsylvania (MCP) is one of the sponsors of the exhibit, which begins with a portrait of 19th century student life at the Woman's Medical College of Pennsylvania (now MCP). The exhibit centers on the college's class of 1879, following its members from graduation through their lives as private and institutional practitioners, medical missionaries, teachers, members and officers of medical societies, and participants in community and family life. Other sponsors are the American Medical Women's Association, the New York Infirmary/Beekman Downtown Hospital, and New York University's Department of History.

By the end of the 19th century over 4,000 American women were practicing medicine, a publication from MCP said Most were graduates of one of 19 wom en's medical colleges. Two pionee women physicians featured in the ex hibit are Ann Preston, MD, former dea of Woman's Medical College of Pennsy vania and founder of the Woman's Ho pital of Philadelphia; and Mary Putna Jacobi, MD, a graduate of Woman' Medical College.

The exhibit is free to the public, an gallery hours are Tuesday through Fr day from 9 a.m. to 5 p.m. A program lectures on 19th century hospital nursing, women in medicine, and pha maceuticals is being presented in co junction with the display.

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Golf Digest(12)	19.94	9.97	9.97
Golf Illustrated(12)	12.00	12.00	6.00
Golf Magazine(12)	15.94	8.97	7.97
#Good Housekeeping(12)	14.97	9.97	14.97
Gourmet(12)	18.00	13.50	15.00
2 yrs(24)		25.00	
Great Foods Mag.(6)	9.95	9.95	7.95
#Harpers Bazaar(12)	16.97	8.97	16.97
Harpers Magazine(12)	18.00	11.97	11.97
Health(12)	22.00	15.97	11.00
High Fidelity(12)	13.95	6.98	6.98
High Technology(12)	21.00	21.00	15.00
Hitchcock Mystery(13)	19.50	19.50	9.97(10)
Hockey Digest(8)	9.95	9.95	7.97
Home(12)	15.00	15.00	11.97
Home Mechanics (12)	11.94	6.94	6.94
2 yrs(24)		13.88	
The Homeowner(10)	18.00	13.97	9.00
Horizon(10)	21.95	16.00	16.00
Horseman(12)	11.95	11.95	7.95
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House and Garden(12)	24.00	18.00	
2 yrs(24)		36.00	
#House Beautiful(12)	15.97	7.99	15.97
Humpty Dumpty:4-7(8)	11.95	9.97	9.97
Hunting(12)	13.94	13.94	9.97
Inc(12)	24.00	12.00	12.00
Income Opportun.(12)	7.95	7.95	3.98(10)
Infoworld(51)	31.00	29.58	29.58
Inside Sports(12)	18.00	11.97	9.97
2 yrs(24)		23.94	
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#Life(12)	27.00	13.50	22.50(10)
M:Civilized Man(12)	24.00	24.00	24.00
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Mademoiselle(12)	15.00	12.00	
2 yrs(24)		22.00	
Medical Update(9)	12.00	12.00	9.95
Metropolitan Home(12)	15.00	7.50	7.50
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National Lampoon(12)	9.95	9.95	9.95
National Law Jnl.(52)	55.00	55.00	27.50
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Needlcrft.for Today(6)	14.00	14.00	10.50
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2 yrs(10)		10.97	
N.Y. Rev.of Books(17)	28.00	28.00	25.95
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Petersens Photog(12)	13.94	6.97	6.97
PHILADELPHIA MAGAZINE(12)		15.00	15.00
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Popular Photogr.(12)	11.97	5.99	5.99
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2 yrs(24)		25.94	
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Seventeen(12)	13.95	13.95	13.95
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2 yrs(24)		35.00	
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Skiing(7)	9.98	4.99	4.99(7)
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Soap Opera Digest(26)	39.00	39.00	29.75
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Sport(12)	12.00	7.97	7.97
Sporting News(26:6 mo)	22.50	12.88	12.88
#Sports Afield(12)	13.97	6.99	13.97
Sports Fitness(12)	26.50	26.50	26.50
#Sports Illustr.(52)	53.50	32.00	26.75(54)
The Star(52)	32.00	19.98	19.98
Stereo Review(12)	9.97	4.99	4.99
Stereophile(12)	20.00	14.97	14.97
Success Magazine(12)	17.94	17.94	8.97
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Tennis(12)	17.94	8.97	8.97
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#Time(52)	58.25	29.25	28.00(50)
#Town & Country(12)	24.00	12.00	24.00
Tours & Resorts(6)	12.00	9.97	9.97
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True Story(12)	14.95	8.97	8.97
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2 yrs(104)		41.00	
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Members collect signatures urging seat belt law

Pennsylvania Medical Society members have collected over 6,000 signatures in support of seat belt legislation. In July, D. Ernest Witt, MD, then the Society president, sent petitions to members and asked them to encourage their family, friends, and patients to support tough legislation requiring the use of automobile seat belts by the citizens of Pennsylvania. The response has been overwhelming; many petitions were returned and more are coming.

In 1984 the PMS House of Delegates resolved to support the concept of seat belt legislation, and encouraged members to educate their patients about seat belts and the benefits of their use.

"Action in the Pennsylvania legislature is expected during the fall session," said Howard G. Hughes, MD, Keystone Safety Belt Network spokesman. "The signatures collected by physicians will help to convince legislators that the people of Pennsylvania want such a law. Surveys indicate that 70 percent favor the legislation, but surveys are not enough. The fact that members of the society cared enough to have people sign petitions, and that more than 6,000 people felt strongly enough to sign a petition, will convince legislators that a law is widely accepted."

Many people have written or talked personally with their senators and representatives to emphasize that they feel a law is needed.

A public hearing on the issue was held in July, and everyone testified in support of seat belts. Dr. Hughes, who also is past president of the Pennsylvania Chapter of the American College of Emergency Physicians, (PACEP) testified before the Senate Transportation Committee. Dr. Hughes told the committee of his experiences as a Life Flight physician. Life Flight is a regional emergency air transport system in central Pennsylvania. "In five years, I have never brought back a patient by Life Flight who was wearing his or her safety belt," said Dr. Hughes. "All of the critically injured patients that I've brought back were *not* wearing their safety belts."

Pittsburgh physicians contribute to book

Three physicians from Pennsylvania have contributed to the third edition of *EveryWoman's Health,* recently published by Doubleday and Company, New York.

Douglass S. Thompson, MD, clinical professor of health services administration at University of Pittsburgh Graduate School of Public Health, served as consulting editor for the book. Frances Drew, MD, MPH, and Toby Orem Graham, MD, both of Pittsburgh, are among the 18 women physicians who provided information for the book, which is a guide to total health care for women of all ages. The book contains chapters on health maintenance, recommendations for examinations, a dictionary of medical terms, generic equivalents to brand name drugs, and listings of health agencies.

Dr. Drew is professor of community medicine and associate dean for student affairs and Dr. Graham is associate professor of medicine at University of Pittsburgh School of Medicine.

The book sells for $19.95.

State releases report on TMI

A report from the state Health Department said there is no evidence of increased cancer among residents of the Harrisburg area since the 1979 accident at Three Mile Island (TMI) nuclear plant but that long-range monitoring will be continued.

State Secretary of Health H. Arnold Muller, MD, called the report the "first scientific analysis of cancer among those living within a 20-mile radius of the plant," adding that the latency period for most cancers would have made an earlier effort premature.

The secretary said the department's study also found no evidence in the area of a significant increase in new cases of leukemia, which has a shorter latency period.

The study covered cancer deaths recorded from January 1974 through December 1983 within 20 miles of the plant, as well as new cancer cases found in four areas downwind of the plant from July 1, 1982, through June 30, 1984.

Dr. Muller said that direct, scientific comparisons between cancer figures in the area prior to the accident and those recorded afterward were impossible to make because of shifts in population and the lack of reliable and necessary data for earlier years—data that now is available through the cancer registry instituted by the state in 1982.

"The next best alternative," he said, "was to compare the number of post-TMI cancers we were able to document with the number that professional statisticians would have 'expected' in the area for the same period."

He said the department's study involved a careful review and analysis of epidemiologic data and statistical records, including death certificates, cancer registry files, TMI census data, TMI registry files, school census data, and physician survey returns.

It also included, at the request of the TMI Public Health Fund Advisory Board and the Citizens Advisory Panel for the Decontamination of TMI Unit 2, a critique of a survey conducted by a local couple, Norman and Marjorie Aamodt, which claimed to have found a dramatic rise in cancer deaths "clearly tied to the TMI-2 accident."

Dr. Muller said the Aamodt allegations are "contrary to scientific findings."

"It is generally agreed that people don't die as quickly from cancer following radiation exposure as these allegations seem to suggest," he said. "On the contrary, it often takes 10 and sometimes more than 20 years for cancers actually to threaten a life. Even if there were any scientific basis for linking the TMI accident to future cancer fatalities in the area," he said, "time itself would seem to rule out any such linkage to deaths that occurred in the past six years."

The Health Department team found that cancer deaths the Aamodts attributed to TMI included people who had been diagnosed as cancer patients prior to the accident, as well as long-term heavy smokers who died of lung cancer; and people who moved into the area after the accident.

The department's study, he said, was reviewed by nationally recognized physicians and scientists who expressed agreement with the findings, as well as the validity of its methods.

The study was headed by George Tokuhata, MD, director of the Health Department's Division of Epidemiology Research, and Edward Digon, a medical research scientist and chief of the department's Special Studies Section.

Feast or Famine

In our society, eating habits vary, and food is often used as more than a source of nourishment. So we accept many individualized patterns.

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Just as the ideal diet for any individual is a matter of proper balance, the ideal treatment for anorexia or bulimia must also be properly balanced and individualized. For this reason, Sheppard Pratt carefully evaluates each patient and tailors a treatment program that draws on all necessary disciplines: medicine, psychiatry and social work. And we administer this treatment intensively, continuously—from inpatient to outpatient to aftercare.

Sheppard Pratt is achieving good results with eating-disordered patients by countering the extremes of feast or famine with a steady diet of multi-disciplinary guidance and care.

For a more detailed description of the Eating Disorders Program at Sheppard Pratt, please contact: Dr. David Waltos, Admissions Officer, Sheppard and Enoch Pratt Hospital, P.O. Box 6815, Baltimore, MD 21204. (301) 823-8200.

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'Ars Medica' exhibit on display in Philadelphia

Ars Medica, an exhibit of 140 prints, drawings, photographs, and rare books showing "art, medicine, and the human condition," will be on display at the Philadelphia Museum of Art until December 1.

The display was assembled from the museum's permanent collection, which spans six centuries from 1400 to 1984, and includes over 1,100 objects. Artists represented by major works include Durer, Rembrandt, Goya, Hogarth, Eakins, Munch, Diane Arbus, and Robert Rauschenberg.

The exhibit is divided into four sections. "Anatomy" traces the interest in anatomical structure from its beginnings in the Renaissance through the 16th and 17th centuries. "Healers: Doctors, Quacks, and Angels of Mercy," shows the changing methods and tools of the healer, and examines people's attitudes toward those providing health care from the Renaissance to the present. "Disease and Disability" focuses on the history of social attitudes toward diseases and disabilities and those afflicted with them. "Allegory, Metaphor, and the Cycle of Life" includes works that depict the physical and emotional vulnerability of the human condition.

A selection of 19th and early 20th century medical and pharmaceutical posters also is on display at the museum through January. The posters advertise such over-the-counter remedies as "Bill Beans For Health," and "Dr. Pierce's Pleasant Pellets."

The museum is open from 10 a.m. to 5 p.m. Tuesday through Sunday. Admission is $4 for adults, $2 for children under 18, students, and senior citizens. Admission is free before 1 p.m. on Sundays.

Other exhibits feature 'art of medicine' theme

Several institutions in the Philadelphia area join the Philadelphia Museum of Art and the Historical Society of Pennsylvania in exhibiting works depicting the visual arts and the history of medicine.

The Free Library of Philadelphia's show on *Art, Medicine, and the Human Condition in Free Library Collections* will run through December 1. Admission is free. The gallery is open 9 a.m. to 9 p.m. Monday through Wednesday; 9 a.m. to 6 p.m. Thursday and Friday; and 9 a.m. to 5 p.m. Saturday.

Graeme Park, 859 County Line Road, Horsham, is exhibiting *Pennsylvania Medical Artifacts* through November 17. Admission is free to see these 18th and 19th century medical cases, instruments, and ledgers. Special tours of the physick garden and house are available. Call 215-343-0965 for more information.

Hahnemann University will feature *Max Brodel at Johns Hopkins: Illustrator and Educator* through December 1. There is no admission charge to see this collection of original drawings by the 19th century founding father of modern medical illustration. The gallery is open 9 a.m. to 5 p.m. weekdays.

Thomas Jefferson University is presenting two exhibits through December 1. A display of *Surgical Instruments of Herculaneum* is at 1020 Walnut Street, and Eakins' *Gross Clinic* and other medical portraits can be seen at 1020 Locust Street. Both shows are free and both are open from 8 a.m. to 5 p.m. Monday through Friday.

Pavilion Gallery of Memorial Hospital of Burlington County, 175 Madison Avenue, Mt. Holly, New Jersey, currently houses works on *The Healing Process Through Art*, as well as *The Medical History of Burlington County*. Both shows are free and will be on display through December 15. The gallery is open 9 a.m. to 8 p.m. daily.

Pennsylvania Hospital will show through December 1 a *Historical Collection of Art and Artifacts*, including paintings and sculpture by Thomas Sully, Thomas Eakins, Benjamin West, and William Rush. The exhibit is free and open from 9 a.m. to 5 p.m. Monday through Friday.

Philadelphia College of Osteopathic Medicine will feature an exhibition of anatomical and pathological specimens, artifacts, and anatomical drawings through December 1. Entry is free, 10 a.m. to 3 p.m. Wednesday and Saturday.

The Philadelphia College of Pharmacy and Science is featuring historical pharmaceutical wares, prints, stamps, drugs, and devices related to the treatment of heart disease in an exhibit called *Ars Medica et Pharmaceutica*, which will be shown through December 1. Admission is free, and the gallery is open from 9 a.m. to 5 p.m. Monday through Friday.

Rosenbach Museum and Library will show *Anatomy as Satire: Etchings by George Cruikshank* through December 1. A fee is charged for entry. The museum is open 11 a.m. to 4 p.m. Tuesday through Sunday.

Three flu strains expected in state

The state Health Department's epidemiologist in charge of monitoring influenza activity during the 1985-86 flu season said recent data suggests three strains of the disease may be present in Pennsylvania over the next six to eight months.

"This year's flu vaccine will include protection against strains closely related to A/Philippines, A/Chile, and B/USSR," said Mary Ann McCarthy, RN, of the department's division of epidemiology. Only one of the three strains, A/Philippines, was confirmed in Pennsylvania last year.

The department recommends annual influenza immunization for adults and children with serious heart or lung disease; for residents of nursing homes and other chronic care facilities; for people who have extended contact with those in high risk groups; healthy people over age 65; and adults and children with chronic metabolic diseases, kidney disease, anemia, or asthma.

McCarthy said children should not be given medications containing aspirin. "We advise against the use of medications containing aspirin for children with influenza because they may increase the risk of Reye syndrome, a rare but serious illness associated with flu and other viral diseases such as chickenpox," she said.

A prescription drug—amantadine—may reduce the severity and duration of illness when given early after infection with Type A influenza viruses. McCarthy said the drug is not effective against Type B influenza.

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capital commentary

1986 critical year for Pennsylvania's senators

Robert H. Craig Jr.
Jerry L. Rothenberger
Larry L. Light

Pennsylvania's two seats in the United States Senate have been held at times by successful and influential individuals who have made their marks in history. They have included the chronicler of the first Senate sessions, William Maclay (1789-1791), George M. Dallas (1831-1833) who was to become James Polk's Vice President in 1845, and James Buchanan (1834-1845), the nation's fifteenth president. Simon Cameron served in the U.S. Senate on three different occasions (1845-1849, 1857-1861, 1867-1877). Cameron also served as Lincoln's secretary of war in the period between his last two Senate terms. Boies Penrose holds the record for longest time in office. He held his seat continuously from 1897 until his death on December 31, 1921.

It became commonplace for governors to seek election to the U.S. Senate when Edward Martin (1947-1958) and James Duff (1951-1957) won such election as their terms in the governor's office were concluding. In 1986, history possibly may repeat itself.

More recently, Pennsylvania's Senate seats were held by Hugh Scott (1956-1976) and Richard Schweiker (1969-1980). Scott was prominent as the leader of the Senate Republican Caucus. After leaving the Senate, Schweiker became the Secretary of Health and Human Services in the first Reagan Administration. The last Democrat to represent Pennsylvania in the U.S. Senate was Joseph Clark (1957-1969). He was defeated by Schweiker in a close 1968 election.

At the present time, H. John Heinz III, the senior senator from Pennsylvania, is also our longest-serving statewide office-holder. He has been in the Congress since he was elected to the House of Representatives in 1972 from a suburban Pittsburgh district. Heinz ran successfully for a seat in the Senate in 1976, defeating Philadelphia Congressman William Green in that election with 52 percent of the vote. He was reelected in 1982, defeating Cyril Wecht, MD, of Allegheny County. Heinz gained 50 percent of the vote while outspending his opponent by about six to one. Heinz' current term expires in 1988.

John Heinz has given an indication that he may also gain a place of prominence in Pennsylvania's political history. During the 1980 elections he chaired the national Republican Senatorial Campaign Committee. In that year control of the U.S. Senate was gained by the Republican Party for the first time in 28 years. He is serving again as campaign chairman for the 1986 elections. It is widely predicted, however, that the Democrats will have their best opportunity so far to regain control, as many "swing" seats held by GOP incumbents are being hotly contested.

The Commonwealth's senior senator has also developed a specialty or expertise which compliments his prowess as a fund raiser for his party. Heinz currently is chairman of the Senate Select Committee on Aging. Although that Committee does not write legislation, the chairmanship has helped him to become recognized as a key and knowledgeable power broker on social security issues. He also serves on the Banking committee, the Housing and Urban Affairs Committee, and the Finance Committee of the Senate.

Most recently Senator Heinz was at the center of the Finance Committee's debate on budget reconciliation issues. He authorized a mandatory second surgical opinion program proposal and was actively involved in the extension of the freeze on nonparticipating Medicare physicians.

Senator Heinz, 46, is a graduate of Yale University and the holder of an MBA from Harvard.

Pennsylvania's junior senator, Arlen Specter, is among those seeking reelection in 1986. A Republican attorney from Philadelphia, he was elected to his first term in 1980.

Specter serves on the Senate Appropriations Committee, Judiciary Committee, Veterans' Affairs Committee, and the Select Committee on Intelligence. He has attempted to be very visible in the role of United States Senator and as a spokesman for Pennsylvania, traveling the state to highlight issues which he believes should attract appropriate attention.

Senator Specter had national exposure as early as 1964, when he was assistant counsel to the Warren Commission, and again from 1966 to 1974 as Philadelphia district attorney. His wife, Joan, is on the Philadelphia city council. Senator Specter lost a senate primary to John Heinz in 1976, and followed that with the loss of a gubernatorial primary in 1978 to Richard Thornburgh. However, in 1980, he defeated the republican state chairman in the primary and then Pittsburgh Democrat Peter Flaherty in the general election. At this time, politicians from across the state are considering who will be making a challenge in both the primary and general elections next year. □

The authors are the staff of the Council on Legislation. Mr. Craig is director, Mr. Rothenberger is assistant director, and Mr. Light is legislative liaison.

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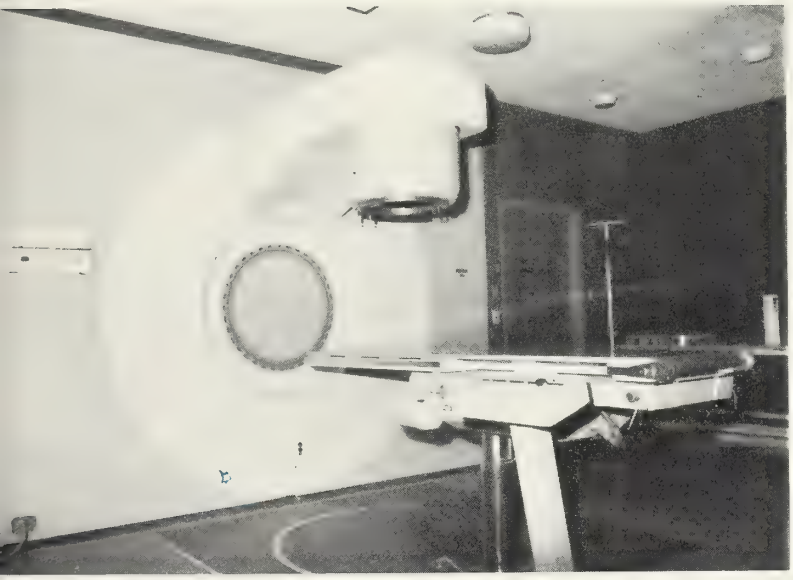

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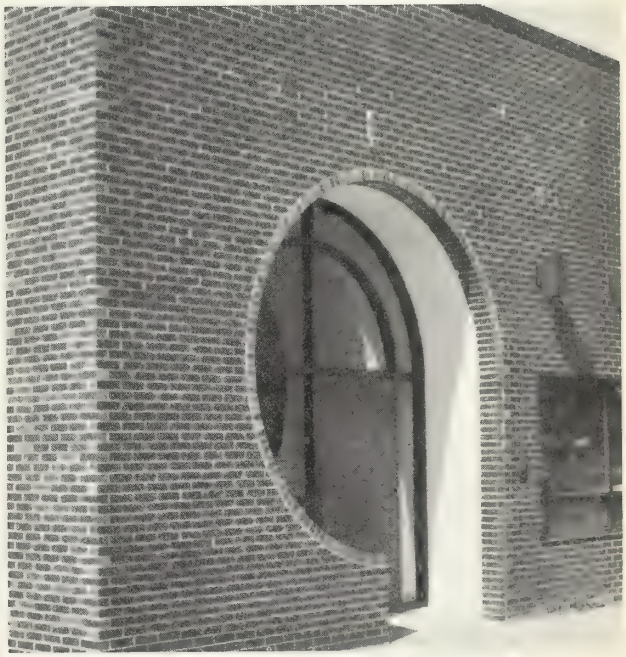

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physicians in the news

Abraham Twerski, MD, Pittsburgh, has left his position as clinical director of psychiatry at St. Francis Hospital, to become full-time director of Gateway Rehabilitation Center. Dr. Twerski, who served at St. Francis for 20 years, founded Gateway Rehabilitation Center, a facility for treatment of alcoholism and drug abuse. **William E. Mooney, MD**, was appointed to succeed Dr. Twerski at St. Francis. Dr. Mooney was previously clinical director of the hospital's mental health center.

James T. Demopoulos, MD, Philadelphia, was elected member-at-large on the Board of Governors of the American Academy of Physical Medicine and Rehabilitation. Dr. Demopoulos is professor and chairman of the department of physical medicine and rehabilitation at Temple University School of Medicine. He also serves as medical director of Moss Rehabilitation Hospital, and as chairman of the department of physical medicine at Albert Einstein Medical Center's Northern Division.

Physicians from Temple University School of Medicine presented two papers at the World Congress of Biological Psychiatry, recently held in Philadelphia. **Charles Shagass, MD**, professor of psychiatry at Temple and principal author of the papers, said their research shows that electroencephalographic measurement can improve diagnosis of psychiatric disorders. **John Straumanis, MD**, professor of psychiatry at Temple also is involved in this research project.

George J. Broder, MD, Rydal, has been appointed chairman of the department of radiology at Jeanes Hospital, Philadelphia. A Board certified radiologist, Dr. Broder has been a member of the hospital's staff since 1969.

Participants in Montgomery County Medical Society's Medical-Legal Seminar are shown above. Seated on the left is William F. Bouzarth, MD, who debated with trial lawyer S. Gerald Litvin, Esq., center, on malpractice issues. Judge Richard Lowe, right, served as moderator.

Two physicians from the Children's Hospital of Philadelphia received a grant to train medical students to be effective managers and health team members. **Robert A. Doughty, MD**, and **Fredric D. Burg, MD**, are two of four investigators conducting a two year pilot program for teaching medical students communication and leadership skills. Dr. Doughty is director of the residency training program and Dr. Burg is senior physician in general pediatrics at Children's Hospital. The W. B. Saunders Company is sponsoring the project through a grant to the National Fund for Medical Education.

William S. Frankl, MD, Philadelphia was installed as president of the American Heart Association, Pennsylvania Affiliate, at the organization's 36th annual assembly. Dr. Frankl is professor of medicine and co-director of the Likoff Cardiovascular Institute of Hahnemann University. He is president and founding member of the Pennsylvania Cardiology Society and a fellow of the American College of Cardiology. Other physicians elected to offices in the Pennsylvania chapter are **Berel B. Arrow, DO**, Lancaster, president elect; and **J. Edwin Wood III, MD**, Philadelphia, vice president of public policy. Dr. Wood was honored as Volunteer of the Year.

Physicians from the Lehigh Valley Hospital Center and the Allentown Hospital are involved in a national program to research treatments for cancer of the prostate. The National Prostatic Cancer Treatment Group is supported by a grant from the National Cancer Institute. Physicians participating are **Edward M. Mullin Jr., MD; John S. Jaffee, MD; Arthur E. Fetzer, MD; Robert Wasko, MD; Paul A. Church, MD; Joseph Pascal, MD; Daniel M. Silverberg, MD; David Prager, MD; Robert M. Post, MD**; and **Lloyd E. Barron, MD**. The physicians will evaluate the effectiveness of various agents and therapies in the treatment of the cancer.

Two Pennsylvania physicians were elected to posts at the annual meeting of the American College of Radiology. **Joseph A. Marasco Jr., MD**, Pittsburgh, was elected chairman of the Board of Chancellors, and **Mark M. Mishkin, MD**, Philadelphia, will serve as a member of the Board of Chancellors.

John C. Cavender, MD was honored by residents of Hop Bottom and Susquehanna County for his service to the community. Dr. Cavender has practiced medicine in Hop Bottom for 38 years.

Matthew R. Hadley, MD was honored recently for his service to the McKeesport community. He practiced there for 20 years.

The town of Madera honored **Roy F. Baker, MD**, by naming their new community hall Baker Hall. Dr. Baker practiced in Madera for 50 years.

Mercer County Medical Society presented a plaque to **Frederick J. Raisch, MD**, for 50 years of medical practice. Dr. Raisch served as a pathologist at Sharon General Hospital.

Trust's loans to students increase $82,100 over 1984

The PMS Educational and Scientific Trust has made loans of $487,350 to 302 students for the 1985-86 academic year, an increase of $82,100 over last year. Medical students account for 234 of the loans, with a total of $415,750. Students in allied health fields account for 43 loans totaling $34,450. Six students who are children of deceased or disabled members and are still dependent on parental support were awarded a total of $13,500. Tax deductible contributions can be made payable to the Educational and Scientific Trust and sent to 20 Erford Road, Lemoyne, PA 17043.

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practice management

Adapting for inevitable changes

Leif C. Beck, LLB, CPBC
Geoffrey T. Anders, JD, CPBC, CPA
Dorothy R. Sweeney

These are strange times for practicing physicians. They are bombarded with warnings that what has been so successful for themselves and their families will soon be totally different. For example, we wrote last January in this publication about "coping with change," and last May 17, *American Medical News* published a major article, "Remodeling the House of Medicine." The so-called medical futurists tell us that private practice as we have known it will soon be a thing of the past.

And yet most (though not all) physicians we encounter have extremely satisfying careers—professionally, financially, and personally. Things are, admittedly, more complex, and the malpractice situation creates a somewhat different mindset, but existing practitioners are generally doing very well. We consultants agonize over how to justify our own readings of changes in medical practice, which truly are dramatic, to clients earning well into six figure incomes with little apparent competition in their specialties or service areas.

Is the current, still good situation simply the calm before the hurricane? Are we instead in the early or middle stages of a slowly changing system in which the "new structure" will take several decades to become the norm? Or will these worries pass as others have in the past, leaving good physicians able to prosper with loyal patients and secure referral patterns?

A mixed bag

We believe the portents of drastic change are real. As discussed in the June issue of PENNSYLVANIA MEDICINE, there are more physicians than are needed and the pressures for lower health care costs will continue. These forces of supply and demand are combining with the discovery by entrepreneurs that health care is indeed highly profitable and creating irreversible trends.

Medicine is, however, such a fragmented industry—primarily made up of hundreds of thousands of solo and small group practices in a huge array of circumstances—that the inevitable changes come at greatly varied rates. An internal medicine practice in Minnesota fails because of the heavy HMO-PPO inroads, but a cardiology group in a small Pennsylvania city enjoys a near monopoly with no likelihood of incoming competition. A very fine otolaryngology group in a New England city encounters four new competitors within six months, while another ENT client in suburban Philadelphia acquires a nearby practice and grows from two to four doctors with an apparently secure practice future. And the forever busy solo family practitioner still has a reception room full of loyal patients who will presumably rely on him until he retires or dies.

Some observers say that change is accelerating to such a degree that even presently successful practices are heading for trouble. We agree that the rate of change is increasing, but we expect a so-called "two-tier system" to exist for five, ten, or even more years—many successful practices of the old style will coexist (though whither away) with the newer style medical practice *businesses*. Some doctors will ride out the changes until they retire or sell out, but younger physicians will have to adapt to the new circumstances in order to have financial and professional satisfaction.

While the former group might thus turn a deaf ear to our concerns for the future, most physicians cannot ignore them. Yet what should a currently successful solo practitioner or small group practice do differently? Does it make sense to tear apart a high income, successful practice in order to reform it to cope with the predicted future? In other words, "If it ain't broke, should you fix it?"

Acting like a business

Whether physicians like it or not, they are engaged in a *business*. The business is to provide quality medical care compassionately to patients, in return for which there should be a reasonable payment. Medicine can no longer ignore business thinking; in fact big business is a major participant whose involvement is just in its infancy.

Given the situation, medical practices should become more like businesses than ever before. This should be done while still emphasizing quality of care, which will be expected in any developing scenario. The concepts of professionalism and profits need not be contradictory.

What characteristics, then, do virtually all other businesses have that are lacking in most medical practices? Here are some of these traits which we predict will dictate either the long term success or demise of private practices.

Essential business-like characteristics

1. *An Entrepreneurial mindset.* While an admittedly vague characteristic, we find that most physicians are woefully lacking in the basic mental approach toward their practices as businesses. This is not surprising. Doctors typically entered medicine because of the scientific or service aspects, and virtually all their training ignored economics and business management. Now, suddenly, these good people are told that their basic thought processes must add an unfamiliar set of ideas.

We expect that young physicians who combine MBA programs with their medical educations will become the leaders of many successful group practices in the future. Similarly, we have encouraged certain physicians to seek out business-related courses, perhaps university night programs or summer sessions, to acquaint themselves with business concepts. While there are a proliferation of practice management seminars on topics ranging from marketing to computers to personnel, such programs have little value in view of the profound changes taking place.

Whether by additional schooling or by personal self-education, physicians should recognize the need for this extra mindset—"thinking like an entrepreneur." It gives a practice the capacity to appreciate more quickly trends affecting its success; it leads to more decisive

The authors are principal attorneys and consultants affiliated with The Health Care Group, Bala Cynwyd.

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action as the so-called "windows of opportunity" open and close; and it fosters receptivity to the many various features upon which all businesses prosper or fail.

2. *Leadership.* Medical group practices, whether two or twenty physicians, routinely function as equal partnerships. Each partner (or shareholder in case of a professional corporation) has an equal vote, and few actions are taken except upon unanimous agreement. In effect, management is so decentralized by respect for each member's position that there is no effective leadership.

Management experts consider it absolutely basic that responsibility and authority rest with a chosen leader—a "chief executive officer." In effect, democracy is the worst form of management!

We are urging clients to shift their leadership format from horizontal (all partners are equally in charge) to vertical (authority leading up to a selected chief) as expeditiously as practicable. Some groups have a natural physician leader to whom acknowledged authority can be delegated. Other groups which lack such an individual or which cannot yet break away from the horizontal style might move toward a two or three doctor "executive committee" as an initial step toward centralizing responsibility.

Physician leaders cannot, of course, be dictators. A CEO's capacity to decide, lead, and take action depends on the partners' consent; there is no power without the backing of the constituents. A leadership format enables the group to respond to business problems and opportunities for the members' benefit without really depriving the members of basic control.

As we consult with new clients in group practices, we feel either optimism or pessimism for long-term success depending on this leadership feature. A common statement among us is, "They're a nice group with a good practice, but I don't see them making needed changes because there's no one to take the lead." Such groups tend to drift, and when crises develop they often flounder and then splinter away.

Solo practitioners are not immune from the need for leadership. Those doctors who exert it tend to create the strongest, most consistent environment for their office staffs. They also tend to be more affirmative in making practice decisions, such as obtaining state-of-the-art equipment and moving to the most desirable office locations. Besides, we see solo practice diminishing so much in the next few years that leadership will become more and more a matter of group dynamics even for presently successful solos.

3. *Accumulation of capital.* Businesses spend money to make money. When they have profits, much of the income is retained and plowed back into making future years still more successful. Medical practices, however, usually function differently; as David J. Ottensmeyer, MD, the former president of the American Group Practice Association, put it:

> "Most medical groups are designed to go out of business on Dec. 31 of every year . . . We take all the capital and drain it out and give it to the physicians and then we start all over again on the first of January."

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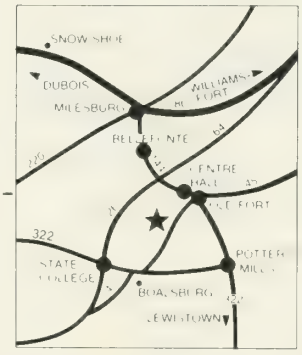

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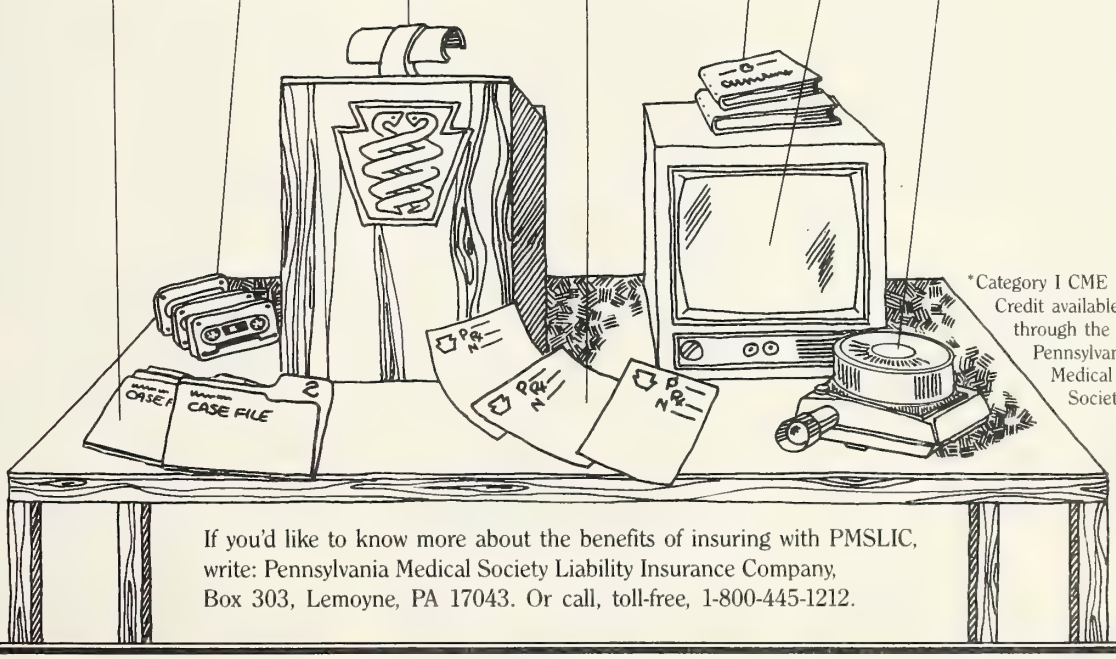

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capital; they must be able to invest their earned dollars in their practices. For example, a solo or small group practice might expect to lose $30,000 in the first year of a newly hired physician's employment, but that new doctor might fill a role in its long term success. The support money for this should be accumulated prior to hiring. Or a major marketing effort might require $50,000 or even $100,000 in order to protect a practice's patient base or to develop and negotiate an employer's health care plan; financing the effort out of accumulated earnings will make the undertaking feasible.

As still another example, we watch the airline companies accept "super saver" rate cuts in order to hold their customer bases for future profitability. Physicians, however, typically flee from virtually any fee concession (including Medicare participation) whether or not patient volume—the lifeblood of a practice's future—will be affected. The concept of accumulating profits in good years and allowing them to be used to support short-term fluctuations as part of long-term business strategies is totally foreign to medical practitioners.

Capital accumulation ties in with borrowing power. Banks are less willing to lend major sums to physicians simply on the basis of predicted future earnings because those predictions are no longer as reliable. Other types of businesses show their balance sheets including accumulated and reinvested earnings, but medical practice balance sheets are comparatively bare. By accumulating capital, a practice can borrow more funds more favorably for major business outlays; and in turn the repayment of those loans is essentially another form of capital usage.

Doctors should leave some of each year's earnings within the practice, thus accumulating a "war chest" for practice development. The strategy would not be a major intrusion on their manner of practice, but would enable them greater business flexibility in succeeding years. And the accumulated fund would be an "alternate retirement fund" for the practice's owner or owners since the capital value increases one's pay-out upon retirement, disability or death.

4. *Attitude towards partnership.* In view of a vastly increasing supply of competent, well trained physicians, staffing one's practice at the doctor level becomes less difficult than in the past. On the other side, we observe an increasing level of "risk aversion" among residents. More young doctors seek only a secure practice position assuring funds to pay off educational loans and support young families. Most do not seek to be entrepreneurs and build big practices.

With qualified physicians more readily available, the traditional characteristics needed in a partner—clinical ability and compatible personality—become less rare.

As we see it, medical partnership should increasingly reflect the special reasons why someone is an owner of a business. The owner controls the sales base (patients and/or referral patterns), manages its operational structure, and works hard at building it as a company. The owner's financial rewards are both profits, presumably through salary, bonus, benefits, and dividends, and increasing value for ultimate buy-out or sell-off. And the owner, typically of an entrepreneurial mindset, also seeks and cherishes the personal gratification of building a successful business—whether medical or otherwise.

Under such circumstances, every young doctor who is well liked in a practice should not become a partner. The senior physician(s) should make this point clear to prospective and actual associates so they will understand what criteria make the difference. We drafted such a policy statement for a client group along these lines:

> "MEMORANDUM"
> XYZ Medical Associates
> Policy as to Shareholder Status
>
> The corporation no longer promises its new physician-employees invitation to shareholder ("partnership") status after any specific time period of continued employment. While clinical ability is, of course, important to continued practice within the group at all, shareholder status will be offered only to those having other characteristics important to ongoing success. These characteristics include leadership ability, entrepreneurial interest and performance, research and teaching activity, willingness to expend personal time for the practice's success, etc.

This is a period of transition for such an idea. Many successful groups have brought young doctors rapidly and easily into partnership within even the past year or two. Young doctors hear of their peers who are promoted in the old style, and expect it to continue as the norm. Changing economics however dictate new policies as to practice ownership and income. We urge clients to recognize the trend but remain flexible enough to recruit and retain their "first choice" young doctor.

5. *Compensation Policy.* As a practice moves more toward the concept that ownership involves capital and entrepreneurialism, it must begin to recognize that an owner's income share should reflect these features. Paying members on their productivity in treating patients ignores the fact that one or more owners are taking business steps to make such production possible—whether by contracting with special sources of patients, maintaining important referral relations or directing the practice's major decisions. Besides, how can one be paid on productivity (which encourages greater utilization) if an increasing portion of the practice's patients present themselves under an HMO or other capitated contract?

We sometimes suggest separating a practice's income into its two underlying segments: (1) return on one's clinical medical service, and (2) return on one's ownership and business responsibility. We recently suggested to a three-doctor practice that it allocate 30 percent of its available income (before doctors' compensation) for equal division due to ownership; the balance of the income will be paid to the three physicians either as agreed salaries based on their time seeing patients or on their traditional "productivity." And even the equal division "pot" might in a later year be distributed differently if one of the owners begins to exhibit disproportionate leadership responsibility.

In another case, we suggested that a small group become a "Subchapter S" corporation. It would then allocate 10 to 20 percent of its available income (before doctors' compensation) as profits, to be distributed only among the shareholders as dividends, not as salaries. All the remaining income can thus be divided in a traditional medical practice formula, on productivity in this specific case, to recognize the return on patient care service. If a young doctor fails to become a "partner," whether because the capital value price is too high or be-

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Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

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cause the entrepreneurial characteristics are not present, he or she can still be paid fully and fairly for work performed as a capable, respected physician.

We believe these newer approaches towards income division are logically suggesting themselves. Just as with attitude towards partnership, group practices should begin to consider them as they reevaluate their arrangements.

6. *Think growth.* Many observers flatly predict the demise of solo medical practice. While we expect some currently successful solo practitioners to maintain their roles for many years, we also expect solo practice to become vastly less common—and less desirable.

Two, three and four doctor groups are not immune. They will be hard pressed to compete effectively for blocks of patients in HMOs or other third party service contracts; they will not be able to afford the expertise of highly paid executive/administrative personnel; and they will not be able to spend comparable funds on marketing, advertising, or new clinical equipment.

As with virtually every other industry, larger companies tend to gobble up or drive out smaller ones. There is every reason to expect the same in medicine, for it is no longer a cottage industry. We expect a handful of multi-billion dollar corporations to begin acquiring and managing medical practices in just the next few years, and we know of one such company that is doing so now.

Such circumstances present both major problems and great business opportunities for practicing physicians. On one hand, doctors can be overrun by the financial clout of practices backed by millions of dollars and scores of capable business executives. How, for example, would a five-doctor general medicine group retain its patient base if a 25-member group spends $1,000,000 a year on advertising and negotiates a contract with an HMO covering one quarter of the area's patients?

On the other hand, well respected group practices may be bought out for really big dollars. Offers even now are beginning to be seen at two to three times average gross income—in cash—where the practice has special significance to a large entity's business plan. And physicians in some bought-out practices report that their practice lives have not changed significantly.

Whether to protect oneself against the potential big competitor or to position oneself for the big buy-out, a larger and better integrated practice will have the best chances for success. A two-doctor group cannot cope against a twelve-physician organization; nor will the big, institutional buyers be particularly interested in buying up two-doctor groups.

Successful smaller practices might thus be on the lookout for mergers and acquisitions of their own. A solo family practitioner might be alert for compatible colleagues so that a merged five-doctor family practice center will result. A five-member group could in turn tie up with two internal medicine specialists, a surgeon, an allergist, etc. to become a ten-doctor regional medical group. And so on.

We are seeing more practice mergers occurring these days than ever before, and we expect the trend to continue. While some proposed mergers should be rejected because the physician-level features, mostly personality, would doom the joinder, the business sense of the trend is clear. The resulting groups have vastly increased opportunities for both self-preservation and long-term success than did their component parts.

Similarly, as solo physicians decide to retire from private practice, existing practices are becoming purchasers. Our own process in helping doctors sell their practices includes inquiry and promotion to other practices within or bordering the seller's service area.

The point here is that the successful practice should be receptive to the possibilities of growing larger, whether by normal development, by merger, or by acquisition. Just as in other industries, long term success is more likely for an organization with a greater "market share" for its products or services. Growth cannot be sought indiscriminately—an ill-advised merger may be disastrous—but its advantages should be recognized so that sensible opportunities are not rejected out of hand.

Conclusion

Physicians who are doing well despite the changing times are sensible not to accept dire predictions out of hand. For the practice that "ain't broke," one should be careful not to fix it too severely. Nevertheless, times do change and our suggested approaches may help many practices adapt and survive while remaining successful during the process. □

JEANES HOSPITAL DEPARTMENT OF MEDICINE— CONFERENCE SCHEDULE WINTER 1985-86

December 4	9:00 A.M.	Clinical Rounds: Nephrology **Melvin Yudis, M.D.** *Chief, Section of Nephrology, Jeanes Hospital*
December 4	12:15 P.M.	CME Conference: Rational Approach to Antimicrobial Therapy **Nelson Gantz, M.D.** *Director, Infectious Disease Clinic* *University of Massachusetts*
December 11	9:00 A.M.	Clinical Pathology Conference
December 18	9:00 A.M.	Morbidity and Mortality Conference
January 8	9:00 A.M.	Clinical Rounds: Neurology **Paul Shipkin, M.D.** **Marcia Halpern, M.D.** *Section of Neurology, Jeanes Hospital*
January 15	9:00 A.M.	Morbidity and Mortality Conference
January 22	9:00 A.M.	Tumor Conference
January 22	12:15 P.M.	Outpatient Management Conference: To Be Announced
January 29	9:00 A.M.	Clinical Rounds: Cardiology **Stanley Spitzer, M.D.** *Section of Cardiology, Jeanes Hospital*
February 5	9:00 A.M.	Clinical Rounds: Infectious Diseases **Israel Lichtenstein, M.D.** *Chief, Section of Infectious Diseases, Jeanes Hospital*
February 5	12:15 P.M.	CME Conference: Pacemakers **Rudolph N. Staroscik, M.D.** *Chairman, Department of Surgery, Jeanes Hospital* **Kevin G. Robinson, M.D.** *Section of Cardiology, Jeanes Hospital* **Joseph R. Carver** *Chief, Section of Cardiology, Jeanes Hospital*
February 12	9:00 A.M.	Clinical Rounds: Allergy and Immunology **Elliot Dunsky, M.D.** *Section of Allergy and Immunology, Jeanes Hospital*
February 19	9:00 A.M.	Morbidity and Mortality Conference
February 26	9:00 A.M.	Tumor Conference
February 26	12:15 P.M.	Outpatient Management Conference: To Be Announced

All programs are scheduled for one hour and held in Stapeley Building 1A.
One hour of Category 1 CME credit per conference.
For more information please call 728-3798.
Jeanes Hospital, 7600 Central Avenue, Philadelphia, PA 19111

special feature

Is rationing of medical care inevitable?

William R. Fifer, MD, FACP

Resources for medical care are finite. They are exceeded by the demand for them, leading many analysts to predict the advent of rationing sooner rather than later. Physicians are concerned that fixed price payments and negotiated care will lead to a decrease in the quality of care.

It is our premise that physicians can forestall, perhaps indefinitely, the advent of rationing by invoking six alternative strategies. These are (1) don't do things that don't need to be done; (2) do what must be done in the most cost-effective manner; (3) enhance efficiency measures; (4) evaluate technologies to determine what works best; (5) create the incentives to use less care; and (6) encourage preventive and health promotion activities.

Each of these strategies is examined by review of a literature which suggests specific steps to accomplish the goal. It is our conclusion that there are practical and achievable alternatives to rationing, and that physician leadership is necessary to invoke them.

It is popular today to accept, with a sense of sadness for what has been lost, the inevitability that the "finest health care system in the world" is faced with rationing its services in the face of finite resources available to it.

Physicians feel concerned, without explicit evidence either way, that the advent of payment by diagnosis-related groups (DRGs) will compromise quality in the inpatient units of service. They are equally concerned that "discount medicine," given by the "preferred provider" can be made available only at the risk of some sacrifice in quality, and they are deeply concerned that the incentives in capitation payments, as exemplified in the HMO movement, reward the physician for *not* doing things for his patient.

Colorado's Governor Richard Lamm has been quoted in *American Medical News* as saying, "unless fiscal responsibility measures (are) instigated immediately, severe health care rationing (will) occur within ten years." He feels that this decade is the "last window of opportunity" for physicians to grasp fiscal realities and concentrate on preventive health measures instead of "baboon and artificial heart transplants."

Aaron and Schwartz, in their thought provoking study, "The Painful Prescription: Rationing Hospital Care," examine the use (and rationing) of medical care resources in a series of clinical settings (renal failure, neoplastic disease, etc.) and conclude that Great Britain has had to ration health care inputs in the face of the cost inflation dilemma.[1]

There is a pervasive dread that rising costs will eventually lead to rationing of medical services, and that inflation is inevitable, given an aging population, robust innovation in technology, and the "free lunch" mentality resulting from the ubiquitous state of health insurance coverage.

It is the purpose of this essay to suggest that only physicians can do something about the cost of medical care, and that there are alternatives to rationing care.

1. Don't do things that don't need to be done.

Under this heading we must include outmoded and discredited practices that, according to third party administrators, still are submitted for payment—such things as basal metabolic rates (BMRs) and cervical glomectomies for asthma! A recent (1981) publi-

cation found that x-ray pelvimetry contributed nothing to the clinical management of 98 percent of the patients for whom it was used,[2] yet it continues to be ordered and paid for by a third party unaware of when and to what degree ultrasound studies can provide better information.

Also included are a myriad of routine studies that contribute little or nothing to solving clinical problems. A recent publication from the Long Beach, California, VA Medical Center noted that, even in a population with a high prevalence of cardiopulmonary disease, routine admission chest x-ray films provided little information that was not already known.[3] These authors recommend that such films not be ordered solely because of admission. Another recent study of the use of screening chest roentgenograms in preoperative patients found that only one patient of 368 who had no clinical risk factors was found to have an abnormal film, and even then the finding did not affect the surgery.[4]

What of the other routine studies (such as CBCs and urinalyses) that often are considered an integral part of a complete routine examination on hospital admission? Shapiro et al. recently analyzed the usefulness of the leukocyte differential count as a case in point. They found that 48 percent and 62 percent, respectively, of the differentials on the medical and surgical services were unjustifiable (according to their criteria) making up 26 percent of all differentials done in the hospital laboratory. They concluded that elimination of only unjustified medical and surgical differentials would permit a reduction of 1.8 full-time equivalent laboratory personnel.[5]

How many other routine studies (Moloney and Rogers called them the "little ticket" items)[6] could be eliminated without clinical consequences? How many routine urinalyses could be accomplished by screening (dipstick) methods without sacrificing quality of care? Studies by the Kaiser system concluded long ago that routine chemistry batteries are not cost justified in asymptomatic patients. All clinicians know how frequently they're engaged in chasing down a "red herring"—an isolated (or spurious) elevation of alkaline phosphatase or positive stool guaiac. Breslow and Somers analyzed the content of the routine annual physical examination and concluded that since many of the elements of such an examination are not cost justified, clinicians should tailor the frequency and scope of examinations to the individual patient's age, sex, and risk factors.[7] The work of David Eddy, which culminated in the publication by the American Cancer Society of guidelines for cancer detection in asymptomatic patients, illustrates the value of applying the theory of probability to clinical decision making and the likelihood that there is considerable money to be saved by avoiding routine examinations.

Many physicians say they order tests known to be of little clinical yield to protect themselves from malpractice (professional liability) claims and suits. It is worth noting that the analyses and guidelines discussed here are continually redefining the "standard of care," departure from which is a requisite to a successful liability action.

Frankly, a certain amount of laboratory testing is done simply because conventional wisdom or clinical protocols seem to demand it. Thus, Jacobson et al. found that clinicians follow a routine when attempting to identify the cause of chronic urticaria. They found that, with the exception of sinus roentgenograms, a host of laboratory studies were of no help in the evaluation of 125 such patients in the absence of suggestive findings in the history and physical examination.[9] They found one (of 99) positive test for antinuclear antibodies, at a cost of $2,670, in a patient already diagnosed by history and physical examination as having systemic lupus erythematosis. They found not a single positive test for ova and parasites despite 120 such examinations at a cost of $1,920. It is unfortunate that so few protocols of this type have been subjected to an analysis of costs and benefits.

Turning our attention to diagnostic and surgical procedures, there is widespread professional concern that many are unnecessary. The American Society of Gastroenterological Endoscopy (ASGE) is concerned about widespread overuse of endoscopic procedures, and is attempting to enforce criteria for their use. In an attempt to curb overuse of respiratory therapy, Blue Cross and Blue Shield plans have issued guidelines for use that require written justification from the prescribing physician. Procedures such as intermittent positive pressure breathing (IPPB), pulmonary function testing, incentive spirometry, chest physiotherapy, and aerosol therapy have been widely used in hospitalized patients. The Congressional Office of Technology Assessment (OTA) estimated in 1981 that 25 percent of all

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'William Y. Rial, MD, AMA president in 1983, stated his belief that we could cut expenditures for health care by 50 percent without a measurable decrease in the healthiness of the American people.'

hospital inpatients receive respiratory therapy at a total cost of $4 billion annually.[10]

Cardiac pacemaker installation has grown rapidly in the past decade and is now a big business (sales of hardware alone amounted to $490 million in 1982). Were all 130,000 implants done in 1981 necessary and appropriate? The Health Research Group released a study indicating that 22.7 percent of the health pacemakers implanted in Maryland patients in 1979 and 1980 were not needed.

The subject of unnecessary surgery could fill a book. Ever since the pioneering second opinion program at Cornell University, the health services research community has been aware of a lack of consensus regarding the indications for many elective surgical procedures. Several specific surgical procedures have been studied in detail: Alison Glover found long ago (1938) marked differences in the rates of tonsillectomy among English school children in different geographic areas, commenting:

> . . . in 1936 a child living in Rutlandshire was nineteen times more likely to undergo tonsillectomy than one living in neighboring Cambridgeshire. A child living in the Enfield area of London was twenty times more likely to have the operation than one in nearby Hornsey. A child living in Bexhill and enjoying the full benefits of its climatic advantages was seen to be twenty-seven times more likely to be submitted to an operation than one living in northerly Birkenhead.

Lewis confirmed Glover's observation of widespread variation in rates of elective surgical procedures in Kansas, and extended the observation to other elective surgical procedures.[11] Bunker postulated that the frequency of surgery related more to the frequency of surgeons than to other variables,[12] an observation confirmed by Vayda's work in Canada. Finally, the careful studies of Wennberg and Gittlesohn established the fact that "small area variation" in the rates of surgical procedures is the rule rather than the exception.[13]

Dyck noted that 24 percent of abdominal hysterectomies were unjustified according to indications specified by the College of Physicians and Surgeons.[14] Cesarian births now account for about 20 percent of all deliveries, double the rate of a decade ago, without good evidence that the increasing rate is appropriate. Indeed, Anderson and Lomas, analyzing the increase in Ontario from 1979 to 1982, found that previous cesarian births accounted for 68 percent of the increase, despite growing challenges by the obstetrical community to the maxim, "once a section, always a section."[15] Many physicians lay the increases in cesarian births in the lap of the medical liability crisis, but whatever the cause a cesarian birth costs twice as much and generates a threefold longer hospital stay than does a vaginal delivery.

Finally, surgical procedures for coronary heart disease may be overused. About 170,000 bypass grafts were performed in 1982, of which an estimated 25,000 did not significantly improve the patient's chance of survival, according to a study sponsored by the National Heart, Lung, and Blood Institute.

Before leaving this topic, we must examine the whole issue of hospitalization, now costing in excess of $500 per day in urban areas. Paul Gertman's studies lead him to conclude that there is marked overuse of hospital and ancillary services in the United States. Using the Appropriateness Evaluation Protocol (AEP) as a tool to evaluate the necessity of hospital use, he found that "one out of eight hospital admissions in Northeast Massachusetts is not necessary . . . that one out of three days of care is inappropriate (and) fully one half of all utilization is unnecessary in some Massachusetts hospitals."

It has been noted for some time that hospital stays are longer, by about two days, in the Eastern as opposed to the Western part of the nation. This difference is not explained by case mix. For example, average stays for acute myocardial infarction range from 15 to 24 days in Baltimore, but only 9 to 12 days in Portland, Oregon.[16] Other studies show that two weeks of hospitalization is just as safe as three weeks for uncomplicated infarcts—the only difference is cost. Studies at Boston's Beth Israel Hospital disclose that short stay (less than six days) cholecystectomy patients did as well as those who stayed over six days, and estimate that a policy of shortened hospital stay for these patients would save $12 million a year.[17] (To put the six day figure in context, the average length of stay for cholecystectomy patients in U.S. hospitals in 1981 was 11 days.) Do shorter stays mean less quality? The renowned Cleveland Clinic now advocates next day discharge following mastectomy!

2. Do what must be done in the most cost effective manner.

Especially since the advent of prospective payment, hospitals have been given the incentive to substitute lower levels of care for inpatient days, since they are paid a fixed price per case by which prolonged stays mean higher costs and reduced margins. This and other developments have caused an intense examination of clinically acceptable substitutions for inpatient days and stays.

The first, well developed, area of substitution is the domain of ambulatory surgery. Free-standing surgicenters have been in operation for 15 years, joined more recently by hospital-based same day surgery programs. Experience indicates that for many procedures hospital admission the night before surgery is unnecessary, and that the patient is ready to go home by late afternoon following morning surgery. Inpatient procedures such as cataract surgery and inguinal herniorrhaphy are now considered suitable outpatient fare, in the absence of systemic disease. A great deal of gynecologic surgery, such as D and C and tubal ligation, can be done in the same day mode, as well as many ENT and arthroscopic procedures.

How did the phenomenon of ambulatory surgery develop? First, it came about because safe and short acting anesthetic agents became available. Second, third party payers began to "steer" patients to the less costly ambulatory alternative. Finally, the peer

review organizations (PROs) forged a professional concensus on what procedures could be done safely in the outpatient mode, as part of their Medicare surveillance activity. As these peer review organizations sought to expand their market beyond the Health Care Financing Administration (HCFA), they entered into private review contracts with business and industry which increased the number of procedures on the ambulatory list. It is estimated that 40 percent of all surgical procedures previously performed in hospital inpatient settings could be done safely as ambulatory surgery. A number of invasive diagnostic procedures, such as upper GI endoscopy, fiberoptic colonoscopy, and coronary arteriography, also were determined effective as outpatient studies.

A host of clinical programs can be done either as outpatient or inpatient procedures. Chronic renal dialysis, for example, can be performed in a hospital setting, or patients may be treated at home. Funding incentives or differences in clinical style may determine where such treatment occurs. Table 1 shows the widely varying percentage of dialysis patients treated at home in various countries of Europe and Israel. Note that 65 percent of dialysis in the United Kingdom is of the home variety while Austria, with about the same number of dialysis patients per million population, treats only 7 percent at home. Table 2 displays the same variation in the United States—note that the neighboring states of Illinois and Indiana, with about the same rate of dialysis per million population, show widely variant (5 percent versus 43 percent) rates of home dialysis. Assuming that peritoneal dialysis is clinically as effective as hemodialysis, and less costly in selected patients, there appears to be a considerable potential for savings in the treatment of patients with chronic renal failure.

Another important arena of care is the management of advanced cancer patients. More and more, chemotherapy is being provided in the outpatient setting, often making use of unneeded inpatient space converted for such special purpose. The hospice concept also has provided the support necessary to manage terminally ill cancer patients at home, without compromising the quality of care.

Another very costly program is the care of the alcoholic and chemically dependent population. The direct cost of alcohol treatment programs exceeded $5 billion in 1977, and was a drop in the bucket compared with the total annual cost, estimated at $120 billion, of alcohol abuse in this country. A recent OTA study said, "Although hospital treatment was significantly more expensive than community-based programs, there was little evidence that either was more effective . . ."[18] At the very least it would seem that better intake evaluation could provide guidelines as to which patients could be treated as effectively in the lower cost setting.

> '. . . invoking the spectre of rationing and the fear of wholesale decline in quality is to sidestep the responsibility of the medical profession to tackle the cost/quality question head on. . .'

The same general observations could be made with respect to psychiatric treatment programs: Many that are carried out in expensive, inpatient settings (often mandated by benefit packages which cover such services) could be done as day care or outpatient activities. Reviewers for Blue Cross and Blue Shield of Minnesota concluded that 3,891 days of inpatient care were unnecessary, representing a savings of $339,000.[19]

Yet another example of doing things in a less costly manner is the whole range of services provided under the rubric of home health care. The concept, of course, is not new—the many Visiting Nurse Associations (VNAs) throughout the country have provided in-home care for decades. The home health industry has grown rapidly in recent years as hospitals have sought to decrease lengths of stay, in order to remain profitable under the incentives of prospective payment. The decline in hospital occupancy has also caused hospitals to explore other lines of business, one of which is home care. Earl Dresser, president of Methodist Hospital in Saint Louis Park, Minnesota, said of the changing health environment, "You don't convalesce in hospitals any more."

As home health services evolved technologically, patients have been provided services at home that previously were available only in the hospital. Intravenous therapy of all kinds is now a commonly provided home health service, including cancer chemotherapy and total parenteral nutrition (TPN). Another commonly employed home service is respiratory therapy such as intermittent positive pressure breathing (IPPB), aerosol administration, incentive spirometry, chest physiotherapy, and oxygen administration.

Health Maintenance Organizations (HMOs) have become sponsors of home health care programs as a means of providing services to enrollees outside of the costly (to them) hospital setting. For example, a patient with an acute flare-up of psoriasis in the old fee for service days would have been admitted to a hospital, smeared with coal tar, and placed under an ultraviolet lamp until, two weeks hence, his skin had cleared and life was bearable again. In the HMO world, that same patient stays at home, is smeared with coal tar, and placed under an ultraviolet lamp by a home health nurse and, two weeks hence, has the same result as the hospitalized patient, but with savings of $7,000 (14 days × $500 per day). Now, patients with acute "medical backs" are sent home, placed in traction in a hospital bed, and provided daily physical therapy. They are admitted to the hospital for myelography and possible surgical intervention only if the condition does not respond to the first treatment.

How much hospitalization is unnecessary? How many things now done in hospitals could be done as outpatient procedures? Restuccia et al. suggest that 37 percent of all Medicare patient days in urban areas of the eastern U.S. are unnecessary.[20] In their national appropriateness evaluation protocol (AEP) study, 19 percent of all hospital admissions and 27 percent of all days were inappropriate. Such studies merely document what thoughtful physicians long have known. Patients whose hospitalization is elective often are admitted for diagnostic tests which are uncomfortable or inconvenient if done as outpatient procedures. Think of

all the irritable colon patients who were provided the "big four" (upper GI, barium enema, oral cholecystogram, intravenous pyelogram) x-ray studies to rule out organic intraabdominal disease. Think how often this was done in the hospital because it was more convenient to the patient or because health insurance covered hospitalization but not outpatient evaluation.

3. Enhance efficiency in the health care system.

How inefficient is the U.S. health care system? In an era that contained no incentives to be efficient, the hospital with the highest staffing ratios, purchasing the most expensive supplies, was reimbursed more because its costs were greater.

We now know that economies of scale flow from horizontal integration (multiple operational units), and we are becoming aware of the management efficiencies of multihospital systems and alliances. If a hospital of 300 beds needs a planning staff of X persons, ten hospitals of 300 beds do not need a planning staff of 10X persons. Data processing, also, can be shared by multiple online hospitals, assuming their systems are compatible.

The same type of savings is possible in a vertically integrated system (one engaged in multiple lines of business) and often is referred to as an "economy of scope." Thus, a hospital may operate an occupational health program, convert underused space to another purpose or program such as behavioral medicine, use swing beds for a long term care program, or provide evening prenatal classes in the same space used for a psychiatric day care program.

The potential to save through group purchasing programs is obvious. A thousand rolls of toilet paper do not cost a thousand times the price of a single roll! But group purchasing has not been exploited to the maximum by any reckoning. Liability insurance can be bought more cheaply by the big buyer, often leading to a self-insurance program or, as in the case of the Hospital Corporation of America, acquisition of a wholly-owned insurance subsidiary.

Contract-managed services (dietary, pharmacy) have the same potential for savings as any other group purchasing program, plus the savings in overhead (one registered dietition or pharmacist can design and supervise a program administered by aides). Filling out the first certificate of need (CON) application "by hand" is a labor-intensive and time consuming job. By the tenth CON for a CT scanner we can take advantage of information stored in the word processor, and simply insert the numbers for a specific facility or service area.

There is an interesting literature developing on the question of whether for-profit hospitals are more efficient than the not-for-profits. Humana, it is claimed, spends only 15 cents on Medicare paperwork that costs most hospitals a dollar, thanks to a single, computerized bookkeeping system which keeps track of 584,000 patients a year from its Louisville, Kentucky, base.

'Restuccia et al. suggest that 37 percent of all Medicare patient days in urban areas of the eastern U.S. are unnecessary.'

It also has been reported that Hospital Corporation of America achieves 15.47 discharges per full time employe while the average U.S. hospital only achieves 13.78. This apparent difference in efficiency must be qualified by noting that HCA hospitals have fewer urban beds than average and fewer Medicare patients than average, as well as a slightly "less sick" case mix index.

4. Evaluate technologies to determine what works best.

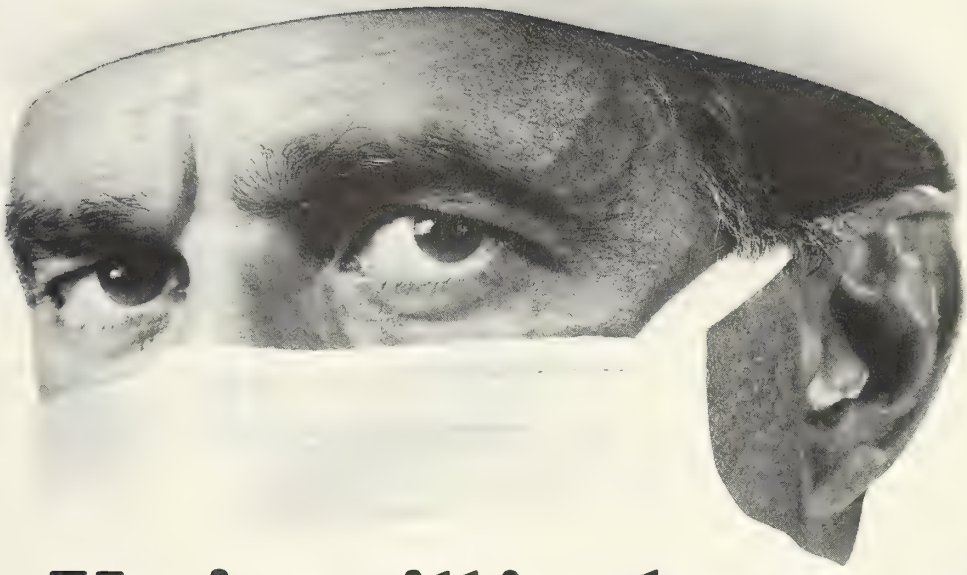
Many analysts have called attention to the urgent need to mount an effective program of technology assessment (T/A) in an era in which expensive technologies are introduced and disseminated empirically. For some reason, our nation has not been able to sustain an ongoing T/A program linked to coverage decisions. Traditionally, the National Institutes of Health (NIH) have conducted T/A activities appropriate to their investigational mission. The OTA has carried out a parallel activity, with little integration to the NIH effort. More recently, an attempt was made to create a major locus of T/A by forming the National Center for Healthcare Technology (NCHCT), but again, the effort could not be sustained.[21] Powerful, vested interests militate against a systematic national program of randomized control trials such as the one that exists in Great Britain. These same interests (Relman has described the "Medical Industrial Complex") seek to prevent any linkage between T/A and coverage decisions (paying only for things of proven value).

At the professional level, the American College of Physicians has implemented a Clinical Efficacy Assessment Program (CEAP), and the Blue Cross Association has used professional counsel extensively in an attempt to identify outdated or ineffective medical interventions.

Meanwhile, practical applications of T/A are being reported by a variety of investigators: Harry P. Selker developed a simple computer program which predicts the probability of acute myocardial ischemia in chest pain patients. Use of the program (which requires only a $100 pocket calculator and 20 seconds time) reduced the number of coronary care unit (CCU) admissions by 30 percent, without any increase in missed diagnoses. When one considers the fact that 1.5 million patients are admitted to CCUs for suspected acute ischemic heart disease (about half of whom do not have it) the use of Selker's program could reduce such admissions by 250,000 per year, at a potential savings of $375 million, with no sacrifice in quality.[22]

Another example of applied technology assessment is the use of the diagnostic radiologist as imaging consultant to the attending physician. It is likely that considerable savings would accrue from more efficient sequencing and choice of imaging modalities in a wide range of clinical circumstances. The use of the radiologist-as-consultant would diminish the number of random and out of sequence upper GI series and barium enemas, performed as part of the diagnostic hunting expedition by the attending. Imagine instead a consultation request stating only "nonpulsatile epigastric mass in a 48 year old male," allowing the imaging consultant to choose and to sequence the most appropriate diagnostic studies.

Arnold Relman testified before the House Select Committee on Aging that 15 to 20 percent of the tests, procedures, drugs, and devices used to diagnose and treat disease are "not worth the money we spend on them." Following that testimony, Representative Claude Pepper, chairman of the subcom-



You're still in charge.

Your first consideration as a physician is the best interest of your patient. Which is as it should be. Undoubtedly, you are also committed to delivering quality health care in as cost-effective a manner as possible. For both of these reasons, you should be interested in our new CPI$_{SM}$ Program and its Quality Care Admission Review$_{SM}$ Program.

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The Quality Care Admission Review Program is designed to help you deliver the best care at the most appropriate site, and thereby assist in containing the cost of group health care. That benefits everyone. As always, though, the final determination is between you and your patient.

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mittee on health, concluded that Medicare could save at least $20 billion in program costs without lessening the quality of care if new technologies were thoroughly tested.[23]

The methodologic tools of T/A are cost benefit analysis (CBA) and cost effectiveness analysis (CEA), and are well described by experts in the field. Defined simply, CBA asks whether the cost of an intervention is justified by the benefit it produces. The conceptual limit of the method is that benefit must be calculated in financial terms, often leading to questions as to the value of a life or the quality of extended life. To illustrate the application of CBA, we know that neonatal intensive care is an immensely expensive way of saving premature infants with low birth weight—whether it is cost justified depends on the value placed on saving lives at the margin, a complex equation.

Cost effectiveness analysis is methodologically more direct in that it compares the cost of different strategies designed to achieve the same worthy outcome. Thus, we may ask whether mobile life support units or smoking cessation programs are more cost-effective in reducing mortality from coronary heart disease, without having to define the value of a saved life in economic terms.

Examples of CBA/CEA are appearing more frequently in the clinical literature: Thus, Layde et al.[24] reported that screening programs to detect and control congenital hypothyroidism yield a cost benefit ratio of 1:8.9. Shapiro et al. reported recently that antimicrobial prophylaxis with cefazolin saved $492 per vaginal hysterectomy and $102 per abdominal hysterectomy.[25] Centerwall and Criqui reported in 1978[26] that the Wernicke-Korsakoff syndrome could be prevented entirely by fortifying alcoholic beverages with thiamine at a cost benefit ratio of 1:23.

TABLE 1
DIALYSIS RATES IN EUROPE AND ISRAEL*

Country	Number of Patients on Dialysis per Million Population	Percentage of Patients Treated at Home
Western Europe and Israel		
Austria	69	7
Belgium	123	8
Denmark	80	30
France	133	20
Ireland	47	34
Israel	144	15
Italy	120	12
Netherlands	92	9
Norway	31	7
Portugal	6	0
Spain	78	7
Sweden	65	22
Switzerland	127	24
United Kingdom	53	65
West Germany	117	25
Eastern Europe		
Bulgaria	17	0
Czechoslovakia	23	0
East Germany	31	0
Hungary	12	0
Poland	8	1
Yugoslavia	43	1

**Source: Combined Report on Regular Dialysis and Transplantation in Europe, IX, 1978. Pitman Medical, Tunbridge Wells, and the Council of the European Dialysis and Transplant Association.*

5. Create the incentives to use less care.

It is becoming trite to reiterate the incentives to provide more care than necessary under an open ended reimbursement system in which the physician receives more fees for more services and the hospital more reimbursement for more costs or charges. Any rearrangement of incentives to reward lesser rates of use has an immense potential to save money without sacrificing quality.

The best evidence of the effect of revised incentives is contained in an analysis of the performance of HMOs, where a fixed monthly capitation fee is paid regardless of the amount of services provided or used. It has been observed that federal employes who choose prepaid group practice (PPGP) plans experience about one half as many elective surgical procedures as those who choose Blue Shield (indemnity) coverage. Other data from the Federal Employes Health Benefits Program (FEHBP) indicate that hospitalization also is reduced by half when these populations choose PPGP care.

Harold Luft observed some time ago that HMOs contain the incentive to reduce hospitalization, resulting in a decrease of 10 to 40 percent lower total costs than are incurred by people with conventional health insurance, largely due to a 30 percent decrease in hospitalization rates.[27] A body of opinion holds that these HMO savings are due to patient selection—that HMOs care for younger and healthier people than those conventionally insured. Recently, however, Manning et al. reported the results of a randomized control trial which confirmed Luft's findings and, by virtue of the study design, tended to eliminate patient variables.[28]

A wealth of similar data depicting HMO rates of hospital use as being from one-half to two-thirds less than fee for service rates tend to support the studies mentioned. It seems clear that altering the incentives on the provider side gets results.

Do HMOs achieve their savings only at the expense of quality? There is no systematic evidence that less care is worse care, and there are recent reports that, in comparable clinical situations, the physician in the HMO does not behave differently from his fee for service counterpart. Cunningham and Williamson reviewed the literature on quality of care which compared HMO and fee for service settings, and could find no difference in quality in the two settings.[29]

What about changing the incentives

Doctor...examine your professional liability insurance coverage. You'll discover you need more.

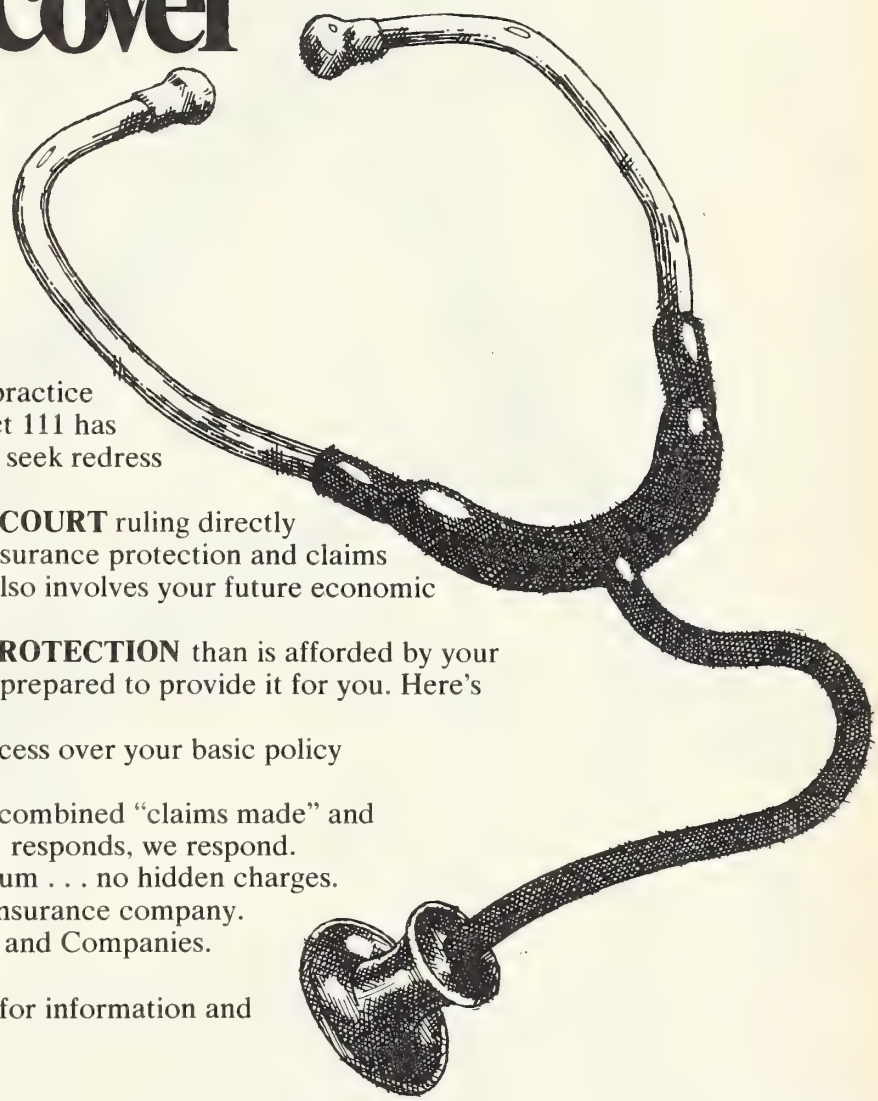

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TABLE 2
DIALYSIS RATES IN THE UNITED STATES BY STATE*

State	Estimated Population in 1979 (Millions)	Number of Patients on Dialysis per Million Population	Percentage of Patients Having Home Dialysis	Transplant Rate per Million Population	Percentage of Dialysis Patients in "For-Profit" Units
Alabama	3.75	212	17	24	38
Alaska	0.38	52	20	0	0
Arizona	2.42	204	9	23	11
Arkansas	2.17	147	20	8	55
California	22.43	232	6	20	57
Colorado	2.73	190	23	19	52
Connecticut	3.10	207	5	15	15
Delaware	0.58	243	13	0	100
District of Columbia	0.65	983	3	122	53
Florida	8.77	274	6	11	48
Georgia	5.06	262	9	15	54
Hawaii	0.86	383	21	55	0
Idaho	0.90	67	23	0	0
Illinois	11.20	197	5	13	49
Indiana	3.40	172	43	16	0
Iowa	2.90	121	30	23	0
Kansas	2.35	130	26	8	4
Kentucky	3.49	119	9	21	60
Louisiana	3.99	238	6	15	58
Maine	1.09	121	8	15	53
Maryland	4.11	183	11	23	62
Massachusetts	5.76	223	10	27	47
Michigan	9.20	175	13	20	16
Minnesota	4.06	134	32	59	0
Mississippi	2.41	203	18	3	13
Missouri	4.85	170	21	26	10
Montana	0.78	109	38	0	0
Nebraska	1.56	113	6	23	0
Nevada	0.69	240	5	0	46
New Hampshire	0.88	85	8	0	73
New Jersey	7.31	242	14	11	24
New Mexico	1.23	173	13	24	62
New York	17.62	282	9	21	12
North Carolina	5.51	188	26	20	76
North Dakota	0.65	96	0	0	0
Ohio	10.72	155	11	24	14
Oklahoma	2.86	139	17	26	32
Oregon	2.52	138	26	27	35
Pennsylvania	11.72	210	14	18	21
Puerto Rico	3.32	159	9	3	64
Rhode Island	0.92	319	1	0	70
South Carolina	2.87	216	13	10	55
South Dakota	0.68	81	0	0	0
Tennessee	4.36	207	20	28	10
Texas	13.24	210	11	19	66
Utah	1.36	174	46	10	28
Vermont	0.49	122	28	22	0
Virginia	5.05	265	14	23	55
Washington	3.88	171	59	18	0
West Virginia	1.88	148	31	3	9
Wisconsin	4.72	120	20	37	9
Wyoming	0.45	20	0	0	100
Total	221.82	204.7**	13.1**	19.4**	36.1**

*All data were adapted from figures supplied by the End Stage Renal Disease section of the Health Care Financing Administration, Department of Health and Human Services, and from the Population Estimates and Projections, Series P-25, No. 876, February 1980, United States Department of Commerce, Bureau of the Census.

**Mean figures calculated from total numbers.

on the consumer side? There is recent evidence that the "free lunch" aspect of care, by which the consumer is insulated from the financial consequences through insurance coverage, is coming to an end. Thus, the number of employers requiring employes to pay deductibles for inpatient hospital care has more than doubled, from 30 percent in 1982 to 63 percent in 1984. Would the imposition of a deductible or copay requirement reduce utilization and hence cost? Brook's studies showed that when patients were required to pay a share of their medical bills, they made one-third fewer visits to physicians and were hospitalized about one-third less often. Did this reduction in the volume of care occur only at the expense of quality? Brook was able to find no significant effects on the health status of the lower users.[30]

Finally, third party payers are beginning to provide incentives to both providers and consumers to use less care. Thus, an innovative Blue Cross/Blue Shield program offers new mothers cash incentives of $50 to $200 to leave the hospital 24 hours after delivery. The estimate is for savings of $300 to $700 per mother under the new plan, which has considerable potential to save big, since the Blues pay for all or part of about one million pregnancies a year.

Michigan Blue Cross/Blue Shield not only encourages hospitals to perform some 80 simple surgical procedures on an outpatient basis, but also provides an incentive to physicians to shift 26 designated procedures from the inpatient to the outpatient setting by paying 125 percent of the normal (UCR) fee if the procedure is done in an ambulatory mode, and only 75 percent of UCR for inpatient surgery.

It goes without saying that many surgical procedures can be done in less costly settings with no compromise in quality. The only consequence is likely to be some loss of convenience for the patient.

6. Encourage preventive and health promotion activities.

When he was Canada's Minister of Health, Marc LaLonde proposed a sweeping reform of the Canadian Health Care System based on the conclusion that the health of Canadians had little to do with the availability of physicians and hospitals. In his now famous monograph,[31] LaLonde documented the relationship between unhealthy and risky life styles and

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premature death and disability in a population. Belloc and Breslow had postulated, earlier, that health status was related more to basic health habits taught in high school classes in personal hygiene than to the amount of medical care received.

Recent reports have focused attention on the immense cost of risky life styles: Luce and Schweitzer reported that the total economic costs of illness attributable to smoking and alcohol abuse was about $60 billion annually, or about 25 percent of the total economic cost of illness to the nation.[32] U.S. Surgeon General C. Everett Koop has said that smoking is responsible for some 340,000 deaths annually and accounts for $14 billion in medical costs each year and over $25 billion in lost production and wages. Berry estimated the economic cost of alcohol abuse in the U.S. in 1971 to be $3.4 billion.

Conversely, evidence is building that wellness pays off: Thus, Dr. Charles Berry estimates that company wellness programs save an average of $310 per employe per year through reduced absenteeism and medical care. When Metropolitan Life tested a fitness program, participants in the program averaged 4.8 sick days a year versus 6.2 days for nonparticipants. Kennecott Copper's wellness program cut sickness 75 percent, absenteeism 53 percent, and the cost of medical care 55 percent, saving six dollars for every dollar spent. General Motors' fitness program at 130 worksites reduced on-the-job accidents by one-half, lost time 40 percent and sickness and accident payments 60 percent.[33]

More and more companies, convinced of the effectiveness of health promotion and disease prevention activities, now offer screening programs for hypertension, pulmonary function testing, diabetes detection, and hemoccult screening programs. They provide health education related to exercise, stress, smoking, nutrition, and alcohol and drug abuse, among other topics. They are direct providers of such services as stress management, weight control, smoking cessation, and fitness programs.

It is less encouraging to report that physicians still do not universally reinforce the importance of preventive and health promotion activities. Occasionally, a breakthrough from traditional medical thought occurs, such as Jack Hall's concept of "prospective" medicine which held, essentially, that a risk-appraisal and modification approach to patient care was preferred to "fixing it after it was broken." Hall encouraged physicians to summon the siblings and offspring of their acute myocardial infarction patient and screen them for coronary risk factors, modifying those that were detected.

In a recent survey of the health promotion activities of physicians, Wechsler et al. found that only 40 percent of general practitioners felt that use of a seat belt was "very important" for the average person. Only 20 percent of internists felt that avoidance of foods high in cholesterol was "very important" for the average person. Indeed, only 47 percent of all physicians routinely ask about their patients' diets, according to the survey.[34]

Conclusion

Six alternatives to rationing medical care hold the promise to delay significantly if not preclude the necessity to ration health services. There is a potential to reduce health care costs with little or no effect on quality. Robert Brook, commenting on the recent publication of Wennberg and others on the variation in the rates of use of medical care, believes that if the lower use rates generally were proved appropriate, there would be no medical cost problem in this country.

There is an immense amount of fat on the cow. William Y. Rial, MD, AMA president in 1983, stated his belief that we could cut expenditures for health care by 50 percent without a measurable decrease in the healthiness of the American people. We agree with Relman that only physicians can do something about the problem of health care costs. We believe that invoking the spectre of rationing and the fear of a wholesale decline in quality is to sidestep the responsibility of the medical profession to tackle the cost/quality question head on, and to provide some sorely needed leadership to help solve an important issue for the nation. □

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obituaries

• *Denotes PMS membership at death.*

• **William C. Dorasavage**, Fort Lauderdale, Florida; Jefferson Medical College of Thomas Jefferson University, 1918; age 91, died August 28, 1985. Dr. Dorasavage practiced surgery in the Pottsville area for 60 years.

• **Clarence Eisner**, Pittsburgh; University of Pittsburgh School of Medicine, 1925; age 84, died August 31, 1985. Dr. Eisner was a general practitioner in Pittsburgh for more than 60 years.

• **James Spratt Faires**, Philadelphia; University of Pennsylvania School of Medicine, 1958; age 53, died September 4, 1985. Dr. Faires was a member of the medical staffs of the Misericordia and Fitzgerald Mercy divisions of the Mercy Catholic Medical Center, and of Riddle Memorial Hospital.

• **Frederick R. Gabriel**, Bradford; Jefferson Medical College of Thomas Jefferson University, 1940; age 71, died August 17, 1985. Dr. Gabriel was a radiologist.

• **Joseph F. Gaughan**, Erie; Jefferson Medical College of Thomas Jefferson University, 1944, age 69; died September 1, 1985. Dr. Gaughan was chief of staff of the alcohol and drug unit at Saint Vincent Health Center, Erie.

• **Alfred A. Grant**, Sugar Grove; Queen's University Faculty of Medicine, Ontario, 1923; age 88, died August 11, 1985. Dr. Grant was a family practitioner in Sugargrove for over 50 years.

• **Mary Hostler Green**, Pittsburgh; University of Pittsburgh School of Medicine, 1947; age 72, died August 25, 1985. Dr. Green was a chemist working with Dr. Jonas Salk when the polio vaccine was developed.

• **Alfred H. Griess**, State College; University of Pennsylvania School of Medicine, 1927; age 85, died September 1, 1985. Dr. Griess served as physician for Pennsylvania State University's boxing and football teams before his retirement in 1966.

• **Robert S. Heller**, Wyncote; Hahnemann University School of Medicine, 1932; age 77, died August 28, 1985. Dr. Heller, an anesthesiologist, served as staff physician at Norristown State Hospital.

• **Karl Valentine Hohman**, McDonald; age 56, died September 2, 1985. Dr. Hohman was a surgeon.

• **E. Clyde Krug III**, Pittsburgh; University of Pittsburgh School of Medicine, 1942; age 69; died August 29, 1985. Dr. Krug was a family practitioner.

• **Frank L. Larkin**, Dunmore; Jefferson Medical College of Thomas Jefferson University, 1934; died August 12, 1985. Dr. Larkin, a urologist, practiced medicine in Scranton for over 50 years.

• **David J. Levison**, Pittsburgh; University of Pittsburgh School of Medicine, 1932; age 79, died August 13, 1985. Dr. Levison was a general practitioner in Pittsburgh for more than 50 years.

• **George Albert McCloskey**, Beaver; Temple University School of Medicine, 1944; age 65, died August 8, 1985. Dr. McCloskey specialized in pediatric allergy.

• **Charles T. McCutcheon**, Upper Darby; Hahnemann University School of Medicine, 1944; age 68, died September 10, 1985. Dr. McCutcheon was a family practitioner.

• **P. Robb McDonald**, Haverford; McGill University Faculty of Medicine, Quebec, 1934; age 76, died August 13, 1985. Dr. McDonald founded the retina service unit at Wills Eye Hospital and was chief of the ophthalmology department at Lankenau Hospital.

• **David Milstein**, Philadelphia; Temple University School of Medicine, 1934; age 78, died August 14, 1985. Dr. Milstein was a general practitioner.

• **Forrest F. Smith**, Chambersburg; Jefferson Medical College of Thomas Jefferson University, 1935; age 76, died August 10, 1985. Dr. Smith was a surgeon.

• **John E. Thompson**, Youngsville; University of Pittsburgh School of Medicine, 1932; age 76, died September 9, 1985. Dr. Thompson served as a general practitioner in the Warren County community for over 50 years.

Philip J. Esgro, Springfield; Hahnemann University School of Medicine, 1944; age 70, died August 9, 1985. Dr. Esgro was the cardiologist of the Veterans Administration outpatient clinic in Philadelphia until 1983.

Joseph C. Ley, Upper St. Clair; University of Pittsburgh School of Medicine, 1945; age 63, died September 2, 1985. Dr. Ley was a psychiatrist.

Edward R. Lucente, Philadelphia; Temple University School of Medicine, 1943; age 68, died August 7, 1985. Dr. Lucente was vice president of ambulatory health services at St. Agnes Medical Center, Philadelphia.

Walter W. Shultz Jr., Lebanon; Philadelphia College of Osteopathic Medicine, 1940; age 70, died August 13, 1985. Dr. Shultz practiced medicine in Lebanon for 45 years.

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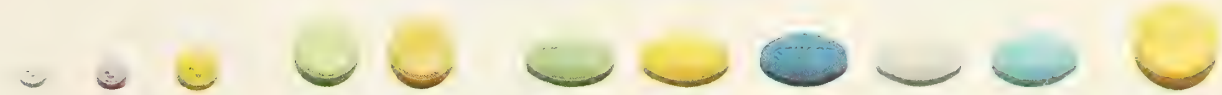

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INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle, therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

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medical feature

Medical conditions and retinal vein obstruction

Gregory H. Scimeca, MD
Larry E. Magargal, MD
Edward A. Jaeger, MD
Eileen Robb-Doyle

Acute occlusion of a branch or the central retinal vein is a serious ophthalmologic condition that requires prompt diagnosis and treatment if permanent loss of vision is to be avoided.[1-16] Clinically, it presents as one of the most dramatic pictures in ophthalmology, thus affording the primary care physician the opportunity to recognize this entity and participate with the ophthalmologist in the management of these patients. In addition, other physicians besides ophthalmologists are often involved in the care of patients with retinal vein occlusion, since many will be found to have underlying systemic vascular disease or hematologic disorders (Table 1).[1-5,8,10,11,15,16] Hence it is important that all physicians not only be familiar with the diagnosis of this entity, but have an understanding of the risk factor associated with its development.

Table I
Conditions Associated with Central Retinal Vein Occlusion

A. Systemic Factors
1. Arteriosclerosis, cardiovascular disease
2. Arterial hypertension
3. Hyperviscosity
4. Polycythemia
5. Anemia
6. Hemoglobinopathies
7. Para and dysproteinemias
   a. Multiple myeloma
   b. Cryoglobulinemia
   c. Macroglobulinemia
   d. Hypergammaglobulinemia
8. Leukemia
9. Diabetes mellitus
10. Chronic lung disease, cystic fibrosis
11. Malignancy
12. Hemodialysis
13. Abnormal fibrinolysis
14. Hyperlipidemia
15. Cryofibrinogenemia
16. Cold agglutinations
17. Hyperurecemia
18. Abnormal liver function tests
19. Use of estrogen containing preparations
20. Increased IgA
21. Temporal arteritis
22. Lupus erythematosis
23. Mitral stenosis
24. Hypercholesterolemia
25. Hypertriglyceridemia
26. Elevated C-reactive protein
27. Platelet-coagulant hyperactivity
   a. Associated with mitral valve prolapse
   b. Idiopathic
28. Migraine
29. Reye's syndrome
30. Pancreatitis
31. Ulcerative colitis
32. Polymositis
33. Syphilis
34. Vasculitis
35. Scleroderma
36. Exercise
37. Renal failure, polycystic kidneys
38. Chrohn's disease
39. Myelofibrosis
40. Paget's disease
41. Ankylosing spondylitis, rheumatoid arthritis
42. Osteoporosis
43. Impaired erythrocyte deformability
44. Hypertriglyceridemia
45. Acute intermittent porphyria

B. Local Factors
1. Open angle glaucoma
2. Trauma
3. Ocular hypertension
4. Extracranial carotid artery obstructive disease
5. Cavernous sinus fistula
6. Carotid-cavernous sinus fistula
7. Hyperplasia of connective tissue of lamina cribrosa
8. Drusen of optic nerve
9. Papilledema
10. Subdural cerebral hemorrhage
11. Optic nerve hemorrhage
12. Arterio-venous malformation

Clinical picture

Patients who experience acute onset of central retinal vein occlusion typically complain of sudden, unilateral, painless loss of vision. In branch vein occlusion, visual loss is usually less severe. On funduscopic examination, hemorrhages are the most prominent feature (Figure 1). They may occur in a wide variety of shapes and sizes, and are concentrated in that portion of the retina drained by the occluded vein and its tributaries. The affected venous tree is tortuous, engorged, dilated, and darker in color. Retinal edema often is present and the disc margin is often blurred or obscurred in central vein occlusion. Cotton-wool patches (soft exudates) are sometimes evident, while the venous pulse is absent. In subacute or chronic states, the fundus picture is less dramatic with all the findings previously mentioned being present, but to a lesser degree. Ultimately, the extent of visual loss depends both on the degree of macular damage and the danger of developing new vessel formation in the retina with subsequent vitreous hemorrhage or on the iris resulting in a secondary neovascular-type glaucoma (Table 2).

Pathophysiology

Although the exact pathophysiologic mechanism producing central retinal vein occlusion is yet to be fully elucidated, a number of investigators feel that the principle systemic condition associated with retinal vein occlusion is arteriosclerosis.[1-16] Since the central retinal artery is a true artery, it may be affected by atherosclerosis. An increased incidence of generalized atheromatous disease often is present in patients with retinal vein occlusion. Mechanical central retinal venous obstruction develops as a result of the close relationship between the retinal artery and vein, which share a common adventitia within the

The authors are from Wills Eye Hospital, Philadelphia.

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Electrophysiologic Testing
Moderator: Scott R. Spielman, M.D.
3 p.m.

Case Presentation: Syncope—*Stuart Snyder, M.D.*
Discussion, Including Results of EP Testing and Control of Ventricular Tachycardia—*Scott R. Spielman, M.D.*
Case Presentation: Supraventricular Tachycardia—*Pasquale F. Nestico, M.D.*
Discussion, Including Results of EP Testing for Bypass Tracts—*Steven P. Kutalek, M.D.*
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Table 2
Risk of Neovascularization

	NVR	NVD	VH	NVI/NVG
1. MVO				
Ischemic	—	—	—	—
2. TBRVO	21	11	70%	1.6
Ischemic	34	18		2.7
3. HBRVO	9	11	57%	8.5
Ischemic	16	21		14
4. CRVO	2	11	10%	20
Ischemic	10	24		60

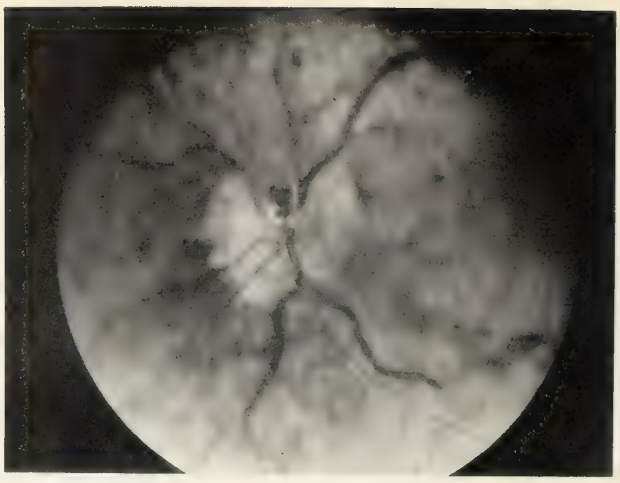

Figure 1 **Fundus with occlusion of the central retinal vein is shown. Note scattered hemorrhages as well as engorgement of the venous tree.**

rigid support of the optic nerve substance or in the retina at an arteriovenous crossing, which is the most common site of branch vein occlusion. Hence, sclerosis of the artery can result in compression or constriction of the venous lumen, leading to turbulent flow, endothelial damage and thrombus formation.

Arterial hypertension also appears to be an important systemic condition associated with branch and central retinal vein occlusions. The incidence of hypertension in patients with retinal vein occlusion ranges from approximately 40 to 70 percent,[1,8,10,15,16] which is at least twice the prevalence in an age matched population. Systemic conditions less commonly associated with central retinal vein occlusion include hyperviscosity conditions, coagulation disorders, hemoglobinopathies, and diabetes mellitus.

Local ocular conditions are also known to be associated with branch and central retinal vein occlusion (Table 1), the most important of which is open angle glaucoma. The prevalence in central retinal vein occlusion of this type of glaucoma ranges from approximately 30 percent[8] to 70 percent.[1,4,5,16] This is a significantly higher prevalence than is found in a matched population sample, whereas open angle glaucoma occurs in approximately 10 to 12 percent of patients with a branch retinal vein occlusion.[8,10,15,16]

Other known local factors associated with central retinal vein occlusion include trauma, congenital anomalies of the retinal vessels, and inflammatory conditions (vasculitis).[1,2,11,16] In young people, platelet coagulation disorders and certain vasoactive medications may promote a venous thrombosis in an otherwise healthy individual.[2,3,4,16]

Treatment

While no medical treatment, including use of anticoagulation or fibrinolytic agents has proven beneficial, low-dose aspirin (20 mg daily) may be used for its anti-platelet aggregation effect.[2,3,16] Persantine (dipyridamole, Boehringer Ingleheim) 50 mg by mouth three times daily and Anturane (sulfinpyrazone USP, Ciba) 200 mg four times daily also have been advocated for patients unable to take aspirin.[3]

In eyes with central retinal vein occlusion and extensive damage to the retinal capillaries (pre-proliferative stage) or in eyes with neovascularization affecting the optic nerve (NVD), retina (NVR) or iris (NVI), laser treatment appears to be beneficial in preventing further visual loss.[1,6,7,16] For patients with branch vein occlusion and macular edema, laser treatment has been shown to improve visual acuity compared to eyes which were not treated.[8,9,10,12,16] □

Table 3
Retinal Causes of
Branch Retinal Vein Occlusion

A. Arteriosclerosis
B. Retinal Vascular Malformation
   1. Angiomatosis retinae (von Hippel's disease)
   2. Telangectasis (Coats' disease)
C. Retinal vasculitis, phlebitis, phlebothrombosis, or infection
   1. Eale's disease
   2. Behcet's syndrome
   3. Toxoplasmosis

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in my opinion

Making it public—will it help?

Naomi Bluestone, MD

"Hey, have a look at this," called my husband from his drawing board. He tossed a newsletter to me, published by the Department of Professional Regulation of the Board of Architecture, State of Florida. On his face was a smirk.

I looked at the back first, an old habit acquired from looking to the op-ed page of The New York Times before facing the headlines. A small blurb informed me that "This newsletter was promulgated at a cost of $3,158 or $.33 per copy to inform licensees about the licensing laws and rules of the Architecture profession."

Page five was bone-chilling, beginning a litany of professional crimes committed by licensees of the state. In bold letters, alphabetically ordered, were names, locations of practice, charges, and punishments. Cotton Mather himself could have done no better. Consider, for example, Architect A, practicing in Orlando:

"Final order issued February 21, 1984; OFFENSES: negligence, dishonest practice, willfully misleading or defrauding; making a false record, fraud or deceit, failing to perform a legal obligation; plans not of sufficiently high standard; ORDER: Stipulation approved for $2,500 fine within one year; reprimand, two-year probation; no admission of guilt."

Or note another wretched miscreant, practicing in Tennessee: "plans not of sufficient high standard; negligence; misconduct; failing to perform a legal obligation; ORDER: Stipulation approved for voluntary relinquishment of license for five years, may petition to reinstate, $2,000 investigative costs within 30 days; no admission of guilt."

A third, in Miami: "OFFENSE: affixing seal and signature to plans which depict work he was not competent to perform; affixing seal to work not prepared by him or under his supervision or by another registered architect; ORDER: Stipulation approved for reprimand, $200 fine within 30 days."

Architect D faced similar charges (as did many others), but also was accused of "aiding, assisting or advising an unlicensed person to practice architecture," for which the order was: "Stipulation approved for two-year suspension, $1,000 fine within 30 days."

Architect E, of Tampa brought a little color to this dreary parade: "OFFENSE: conviction of a felony or misdemeanor involving moral turpitude; ORDER: Suspension until he has exhausted his pending request for judicial review of his conviction or until said conviction is reversed or vacated by an appropriate court."

In all, 30 men and one woman faced the wrath of the forces of discipline and order down in Florida over a 34 month period. And everyone, in the profession at least, knows exactly who they are.

News of the activities of the Board rounded out this interesting little policing document. It offers food for thought. I have faced stark lists of wrong-doers before. The local shopper that serves the small town in New Hampshire where we vacation devotes two whole weekly columns to the prurient interests of law-abiding citizens, where crime is concerned. "News from the Traffic Court" lists every kid in town convicted of that most horrendous charge, DWI. Driving while intoxicated is not taken lightly in New England, and hefty fines and license suspensions are made known to parents, employers, neighbors, and girlfriends alike. Running red lights, passing stop signs, driving an unregistered vehicle—all these violations of the pub-

Dr. Bluestone is in the private practice of psychiatry in Great Neck, New York. A freelance writer, she contributes frequently to PENNSYLVANIA MEDICINE. *Besides her medical degree from the Medical College of Pennsylvania, Dr. Bluestone has a master's degree in public health. She is the author of the book,* "So You Want to be a Doctor," *and has written and published over 100 articles on various health care topics.*

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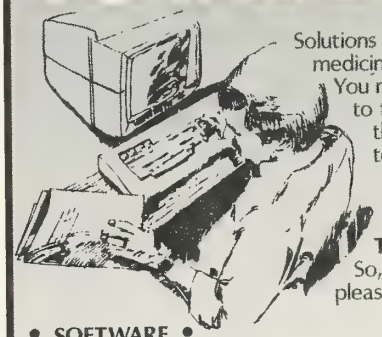

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lic decency are published remorselessly. It is unknown to what avail, but it certainly makes juicy reading for a small town.

Similarly, the grosser malefactions are issued in the other news from court. In short order, we are informed about every breaking and entry, every petty larceny, every unleashed dog, every violation of the hunting laws. Possession of drugs, burglary, car liberations—you name it, the citizens will read it. And presumably wreak their restrained vengeance.

Even the Big City is not immune from a desire to make known the heresies and infractions of others. When I was a resident in preventive medicine at the City of New York Department of Health, one of our tasks was to make rounds with the sanitarians, who periodically and in sneak attacks wrought terror in the lives of restaurant owners in all five boroughs. We would make early morning raids, shouting "DEPARTAMENT-DAY-SALUD" and flashing impressive credentials. Hispanics, Orientals, and Italians alike would cower as we revealed, with flashlights, mirrors, and pen-knives, evidence of roach and other vermin infestations, mouse-droppings, rat runs, pots and pans encrusted with food, counter corners baked in filth, and rotting leftovers still in the fridge for the upcoming days' menu. It was not until years later that health workers were permitted to publish this information in the newspaper, although fortunately not in its gory detail. For months, New Yorkers had a daily digest of which restaurants were being reprimanded, upgraded, or closed. Invariably the list sported favorite eating places, which now evoked only the gag reflex in readers. And—interesting moral—the best places in the city made the list as steadily as the hash joints and movable feasts of the ghetto. Sleaze did not respect pretensions or pocketbook, and New Yorkers started watching where they ate.

Managing malefactors

The publication of lists of wrongdoers by the architects of Florida is certainly not new. But I must confess it is the first time that I have seen it done by professionals, for professionals, in an organized and funded manner. I found it sad, revolting, important, impressive, and thought-provoking.

Inevitably, I was forced to conclude that never had I seen a similar list of errant physicians. The imagination gasps trying to conjure up an analogous list for medicine: Dr. A is accused of Medicaid fraud, including family ganging, ping-ponging, steering, kiting, Sunday billing, and claiming follow-up visits at comprehensive examination rates. Dr. B is accused of unnecessary surgery, substandard pre-op orders, and fraudulently predicting outcomes. Dr. C is reprimanded for failure to write daily notes or to dictate his discharge summaries in timely fashion. Dr. D is charged with "undue familiarity" with female patients.

Are we to review this newsletter from Florida, and do likewise? Are we to publish a list of our failures, and to what avail? How routine this list seems, how very ordinary! What will be the fate of these people, and how will their lives and practices be changed by their colleagues' recognition that they have betrayed a public trust and a professional expectation? Is it possible that this list ultimately will not have the effect desired? Are there better ways?

Physicians often are accused of failing to police themselves. Not true. They police themselves all the time. No one can escape the wagging tongues and upraised eyebrows of critical colleagues, unless he practices in the remote hinterlands, where mistakes are buried without comment (except from an increasingly suspicious populace)! The problem lies not in failing to uncover, but in failing to devise a satisfactory system for the management of known malefactors.

The weaknesses of the medical sanctions system are not unlike the inadequacies of the criminal justice system. Solutions are ambiguous, chancy, lacking a cohesive point of view. Plea bargaining prevails. There are committees that get some physicians off the hook by lumping the degenerate and the sick together, the way almshouses and prisons used to share a common home and clientele. There are committees that rehabilitate the offenders, with programs of confrontation, education, restitution, and supervised re-entry. There are those who choose to banish the bad apples, unleashing them on

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PMS fought to reduce vehicle injuries and death by playing a lead role in the passage of the Pennsylvania child safety seat law. Now, your Society is working for a mandatory seat belt law so everyone in Pennsylvania will be "buckled up."

PMS fought against medical incompetence. As a result, the State Board of Medical Education and Licensure can immediately suspend a physician's license if he or she is a danger to public safety, or is convicted of a drug-related felony. Hospitals and other health care facilities must also report to the State Board if a physician has been fired, disciplined, or convicted of a felony.

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neighboring hospitals or the opposite coast, where they are free to repeat their cycles *ad libitum*. There are the lily-livered who look aside, finding the rendering of judgments distasteful. And there are the realistic, who shoulder the burden of exerting some peer pressure to persuade the spotted physician to shape up. I have even known physicians who take on the work of the negligent, out of respect, affection, political necessity, or pity. (For example, I remember a great pioneering woman surgeon from my training days, who was so long past her prime that her residents simply arranged never to leave her alone in the O.R.) Nor should we forget the bureaucratizers, who try to forestall problems by the imposition of onerous paper regulations, each of which is supposed to prevent a particular evil. And I suppose there are those who believe the problem would be solved magically if we published a list of offending doctors, with all their misdeeds exposed like dirty real estate transactions.

Inadequacies of physician self-policing have always been attributed to the traditional reluctance of physicians to point fingers. ("There but for the grace of God go I.") This seems to me an off-target explanation, which probably credits us with more humility than we truly possess. There is a strong streak of self-righteousness in well-trained physicians, nicely triggered by patent incompetence and venality in our colleagues. More likely our unwillingness to deal with bad apples refers to the natural reluctance of any human being to deal with sleaze head-on. It's upsetting, contaminating, and tempting.

Another dilemma for most physicians is deciding when to blow the whistle. At what point do differences in clinical judgment, ethical standards, and levels of competence become irreconcilable and reportable? Attempts to draw a line beyond which behavior is completely unacceptable meet with regional differences, inadequate proof, extenuating circumstances, and the taboo which renders all the above doubly difficult. Early warning systems are as inadequate in halting bad physicians as they are in preventing tertiary disease.

The problem of the incompetent, sick, or criminally negligent physician is a real one, and many states have made good inroads into handling it. Most do it with a level of secrecy, discretion and subtlety that seems incompatible with an annual register of "bad doctors." It might be an interesting exercise for each reader to try to come up with his own unwritten list, drawn from his or her own circle of colleagues. How could you prove your allegations? How would you treat such a person? How many others could corroborate your impressions? And how many would be willing to stick their necks out to keep the medicine barrel pure?

Interesting questions. □

Tax reform—yes; tax on fringe benefits—no

Arlen Specter

Nothing in life is certain except death and taxes. But nothing is more uncertain than when death or medical problems will occur, or how to tax fairly, simply, and efficiently. In order to counter the risks of life, many Americans protect themselves with comprehensive health plans. And, in order to achieve a fair, simple, and efficient tax code, Americans need tax reform.

In late May, President Reagan submitted a bold plan for tax reform to Congress. Although I believe that Americans want reform, the Administration's plan raises many issues for debate.

Knowing of the impact that such changes could have on medical insurance programs, which are so important to members of the Pennsylvania Medical Society, I want you to be aware of my position regarding this section of the tax reform package.

I oppose any attempt to tax fringe benefits. At a time when working families in Pennsylvania are under severe financial pressure, we simply cannot justify adding to their burdens by this kind of change in the tax code.

Company sponsored benefits provide a decentralized and effective means of keeping employes healthy, encouraging savings, and providing income in the event of disability, death, or retirement. According to the U.S. Bureau of Labor Statistics, 82 percent of full time workers in medium and large firms have employer provided pension protection. The same survey also indicates that 96 percent of full time workers have employer-provided life and health insurance protection.

Maintaining a viable system of decentralized health and life insurance, pension plans, and other employe benefits is vital for Pennsylvania and for the nation as a whole. This is particularly true in the area of group family coverage. This is especially important in order to encourage preventive care.

The Administration has proposed including employer contributions to health plans in a worker's income up to $10 per month ($120 per year) for individual coverage and up to $25 per month ($300 per year) for family coverage. By taxing as income the value derived from company sponsored health insurance policies, the cost of maintaining adequate coverage could rise beyond the reach of most Americans.

Members of your association have informed me that these provisions in the Administration's tax proposal would drastically affect the ability of people to afford medical services. This in turn would have an adverse effect on the members of your association who fulfill this vital human need.

With the publishing of the Administration's tax proposal, President Reagan has taken a crucial first step towards tax reform. But as a member of the Senate, I have the responsibility to scrutinize this plan in order to ensure that the final package reflects fairness and efficiency. I intend to oppose any changes which would limit your ability to provide important services unless a broad consensus develops that these changes are necessary to achieve greater simplicity and fairness.

I appreciate the opportunity to express my thoughts and urge you, your families and friends to contact me and all other members of Congress to express your views on these important issues. □

The author is the junior United States Senator from Pennsylvania.

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Psychiatrist — Board certified or Board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Pennsylvania license required. Contact Mrs. Kathleen D. Reese, ACSW, Superintendent, Clarks Summit State Hospital, Clarks Summit, Pennsylvania 18411; (717) 586-2011.

Emergency physicians — Emergency medicine opportunities available for career oriented medical directors and staff physicians licensed in MD and/or PA. Full and part-time positions available. Applicants must have a minimum of 2 years recent experience. Competitive income and malpractice insurance provided. Please send CV to Sally Bowen at 6227 Executive Blvd., Rockville, MD 10852, or call (301) 984-0353.

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Desirable central Pennsylvania location — otolaryngologist (ear, nose, throat surgeon). Solo practice with cross coverage available. American Board affiliation required. Area has recreational advantages. Assistance available. Write to Box 134, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

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The Pennsylvania Medical Society is accepting applications for a full-time medical director to manage the newly-expanded impaired physician program. Qualifications for this position should include:

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- Reputation for integrity.
- Excellent physical and mental health.
- Qualify for license to practice medicine in Pennsylvania.

In addition to the foregoing professional requirements, applicants must be eligible for membership in the Pennsylvania Medical Society and be able to relocate to the Harrisburg, Pennsylvania area. Applicants must be able to submit to an intensive investigation.

All applicants should submit a letter of application, curriculum vitaes, and salary requirements to the **Pennsylvania Medical Society, Abram M. Hostetter, MD, Chairman, Committee on the Impaired Physician, 20 Erford Road, Lemoyne, PA 17043. Reply deadline is December 15, 1985. The position will begin effective on or about January 1, 1986.**

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have a minimum of two years recent emergency department experience. ACLS required. Competitive salary, malpractice insurance, medical society memberships provided. Please send CV to Dr. David A. DeHart, 103 Frick Road, Pittsburgh, PA 14238 or call (412) 578-5442.

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Ob-Gyn, Board-certified, minimum 3-years experience, desired to join busy ob-gyn practice in Bucks County, Pennsylvania. Please send curriculum vitae to Post Office Box 401, Newtown, PA 18940.

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Part-time and temporary positions located — Choose from part-time and temporary practice opportunities throughout Pennsylvania in the new Locum Tenens Section of the Pennsylvania Medical Society's Physician Placement Service. For more information, contact Tim Smith, PMS Physician Placement Service, 20 Erford Road, Lemoyne, PA 17043; (717) 763-7151.

Internist wanted in Harrisburg. Board certification in internal medicine preferred. Solo, salary. Size of community and trade area: 100,000 and greater. Respond to PMS Physician Placement Service, Department NOM-0486-IM21, 20 Erford Road, Lemoyne, PA 17043.

Rheumatologist/internist wanted. Board certified or eligible. Partnership, salary or salary plus percentage. Size of community: 10,000 - 30,000. Size of trade area: 30,000 - 100,000. Respond to PMS Physician Placement Service, Department COM-0486-OS02, 20 Erford Road, Lemoyne, PA 17043.

Family practitioner wanted. Must be Board certified or eligible in family practice. Solo practice, fee for service — minimum guarantee. Size of community: 10,000 - 30,000. Size of trade area: 30,000 - 100,000. Respond to PMS Physician Placement Service, Department NON-1285-FP57, 20 Erford Road, Lemoyne, PA 17043.

Internist wanted. Board certified or eligible in internal medicine. Partnership, salary, or salary plus percentage. Size of community: 10,000 - 30,000. Size of trade area: 30,000 - 100,000. Respond to PMS Physician Placement Service, Department COM-0486-IM22, 20 Erford Road, Lemoyne, PA 17043.

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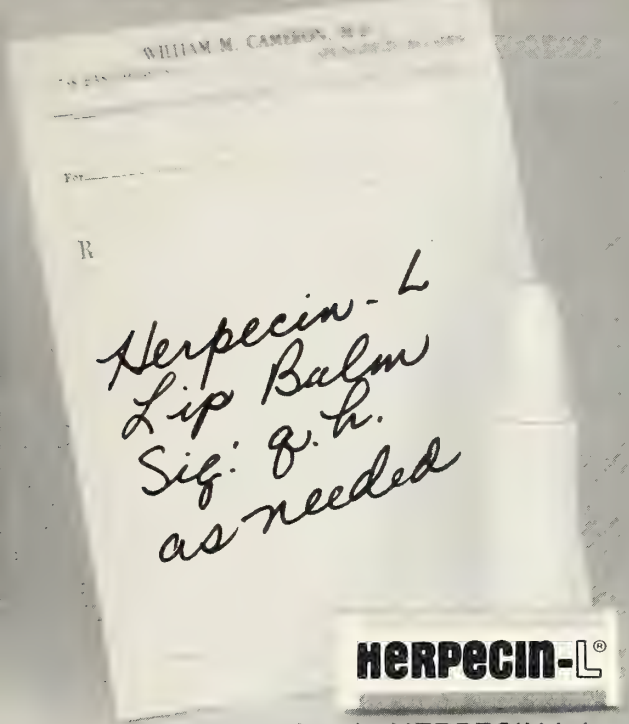

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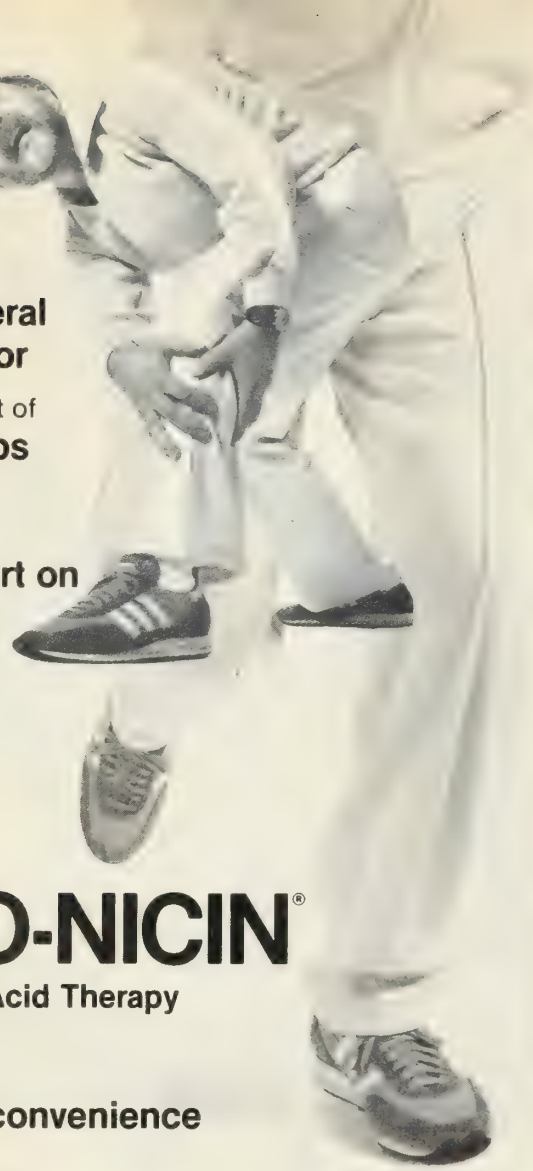

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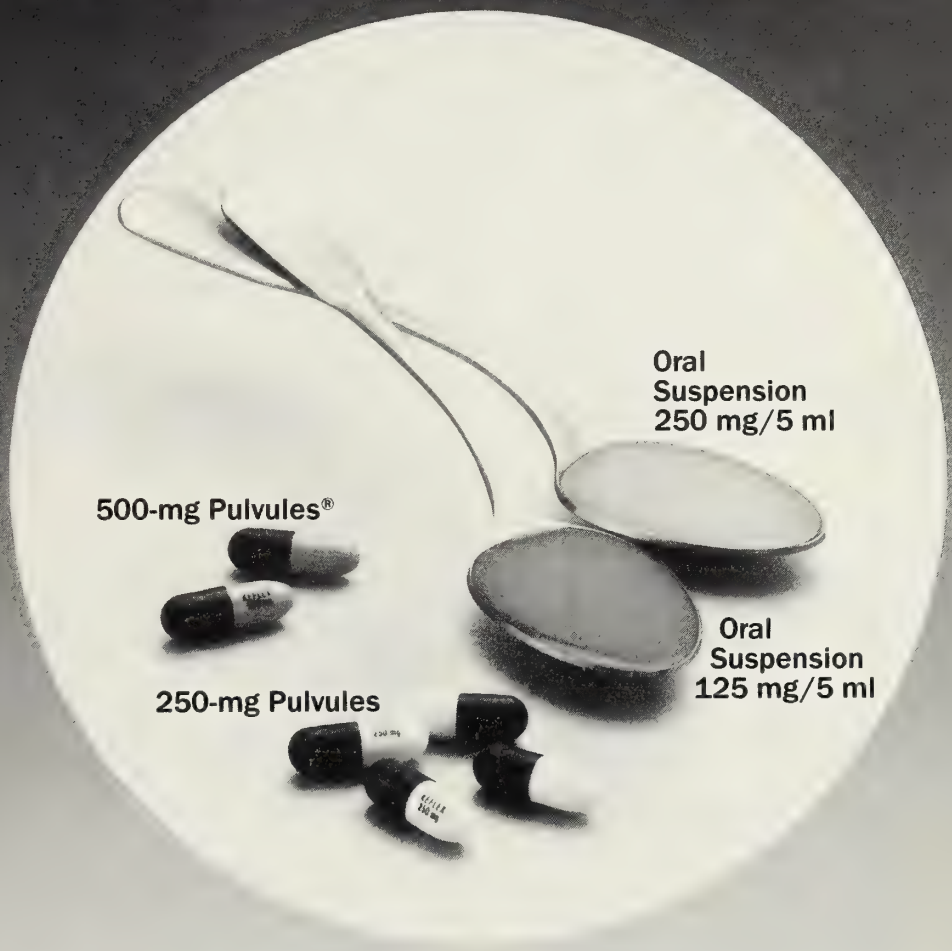

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Before prescribing, please consult complete product information, a summary of which follows:

CONTRAINDICATIONS: Hypersensitivity to trimethoprim or sulfonamides; documented megaloblastic anemia due to folate deficiency; pregnancy at term and during the nursing period; infants less than two months of age.

WARNINGS: FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS.

BACTRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. Clinical signs, such as rash, sore throat, fever, pallor, purpura or jaundice, may be early indications of serious reactions. In rare instances a skin rash may be followed by more severe reactions, such as Stevens-Johnson syndrome, toxic epidermal necrolysis, hepatic necrosis or serious blood disorder. Perform complete blood counts frequently.

BACTRIM SHOULD NOT BE USED IN THE TREATMENT OF STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have a greater incidence of bacteriologic failure when treated with Bactrim than with penicillin.

PRECAUTIONS:

General: Give with caution to patients with impaired renal or hepatic function, possible folate deficiency and severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur, frequently dose-related.

Information for Patients: Instruct patients to maintain adequate fluid intake to prevent crystalluria and stone formation.

Laboratory Tests: Perform complete blood counts frequently; if a significant reduction in the count of any formed blood element is noted, discontinue Bactrim. Perform urinalyses with careful microscopic examination and renal function tests during therapy, particularly for patients with impaired renal function.

Drug Interactions: In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported. Bactrim may prolong the prothrombin time in patients who are receiving the anticoagulant warfarin. Keep this in mind when Bactrim is given to patients already on anticoagulant therapy and reassess coagulation time. Bactrim may inhibit the hepatic metabolism of phenytoin. Given at a common clinical dosage, it increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When giving these drugs concurrently, be alert for possible excessive phenytoin effect. Sulfonamides can displace methotrexate from plasma protein binding sites, thus increasing free methotrexate concentrations.

Drug/Laboratory Test Interactions: Bactrim, specifically the trimethoprim component, can interfere with a serum methotrexate assay as determined by the competitive binding protein technique (CBPA) when a bacterial dihydrofolate reductase is used as the binding protein. No interference occurs if methotrexate is measured by a radioimmunoassay (RIA). The presence of trimethoprim and sulfamethoxazole may also interfere with the Jaffé alkaline picrate reaction assay for creatinine, resulting in overestimations of about 10% in the range of normal values.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Long-term studies in animals to evaluate carcinogenic potential not conducted with Bactrim. *Mutagenesis:* Bacterial mutagenic studies not performed with sulfamethoxazole and trimethoprim in combination. Trimethoprim demonstrated to be nonmutagenic in the Ames assay. No chromosomal damage observed in human leukocytes *in vitro* with sulfamethoxazole and trimethoprim alone or in combination; concentrations used exceeded blood levels of these compounds following therapy with Bactrim. Observations of leukocytes obtained from patients treated with Bactrim revealed no chromosomal abnormalities. *Impairment of Fertility:* No adverse effects on fertility or general reproductive performance observed in rats given oral dosages as high as 70 mg/kg/day trimethoprim plus 350 mg/kg/day sulfamethoxazole.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Trimethoprim and sulfamethoxazole may interfere with folic acid metabolism; use during pregnancy only if potential benefit justifies potential risk to fetus. Nonteratogenic Effects: See CONTRAINDICATIONS section.

Nursing Mothers: See CONTRAINDICATIONS section.

Pediatric Use: Not recommended for infants under two months (see INDICATIONS and CONTRAINDICATIONS sections).

ADVERSE REACTIONS: Most common are gastrointestinal disturbances (nausea, vomiting, anorexia) and allergic skin reactions (such as rash and urticaria). **FATALITIES ASSOCIATED WITH THE ADMINISTRATION OF SULFONAMIDES, ALTHOUGH RARE, HAVE OCCURRED DUE TO SEVERE REACTIONS, INCLUDING STEVENS-JOHNSON SYNDROME, TOXIC EPIDERMAL NECROLYSIS, FULMINANT HEPATIC NECROSIS, AGRANULOCYTOSIS, APLASTIC ANEMIA AND OTHER BLOOD DYSCRASIAS (SEE WARNINGS SECTION).** *Hematologic:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, neutropenia, hemolytic anemia, megaloblastic anemia, hypoprothrombinemia, methemoglobinemia, eosinophilia. *Allergic Reactions:* Stevens-Johnson syndrome, toxic epidermal necrolysis, anaphylaxis, allergic myocarditis, erythema multiforme, exfoliative dermatitis, angioedema, drug fever, chills, Henoch-Schoenlein purpura, serum sickness-like syndrome, generalized allergic reactions, generalized skin eruptions, photosensitivity, conjunctival and scleral injection, pruritus, urticaria and rash. Periarteritis nodosa and systemic lupus erythematosus have been reported. *Gastrointestinal:* Hepatitis (including cholestatic jaundice and hepatic necrosis), elevation of serum transaminase and bilirubin, pseudomembranous enterocolitis, pancreatitis, stomatitis, glossitis, nausea, emesis, abdominal pain, diarrhea, anorexia. *Genitourinary:* Renal failure, interstitial nephritis, BUN and serum creatinine elevation, toxic nephrosis with oliguria and anuria, crystalluria. *Neurologic:* Aseptic meningitis, convulsions, peripheral neuritis, ataxia, vertigo, tinnitus, headache. *Psychiatric:* Hallucinations, depression, apathy, nervousness. *Endocrine:* Sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents; cross-sensitivity may exist. Diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. *Musculoskeletal:* Arthralgia, myalgia. *Miscellaneous:* Weakness, fatigue, insomnia.

DOSAGE AND ADMINISTRATION: Not recommended for use in infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN: *Usual adult dosage* for urinary tract infections is one DS tablet, two tablets or four teaspoonfuls (20 ml) *b.i.d.* for 10 to 14 days. Use identical daily dosage for 5 days for shigellosis. *Recommended dosage for children* with urinary tract infections or acute otitis media is 8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses every 12 hours for 10 days. Use identical daily dosage for 5 days for shigellosis. *Renal Impaired:* Creatinine clearance above 30 ml/min, give usual dosage; 15-30 ml/min, give one-half the usual regimen; below 15 ml/min, use not recommended.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS: Usual adult dosage is one DS tablet, two tablets or four teasp. (20 ml) *b.i.d.* for 14 days.

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HOW SUPPLIED: *DS (double strength) Tablets* (160 mg trimethoprim and 800 mg sulfamethoxazole—bottles of 100, 250 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets* (80 mg trimethoprim and 400 mg sulfamethoxazole)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 100 ml and 16 oz (1 pint). *Suspension* (40 mg trimethoprim and 200 mg sulfamethoxazole per teasp.)—bottles of 16 oz (1 pint).

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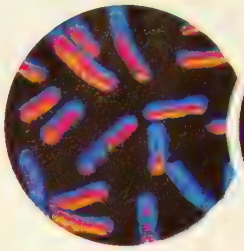
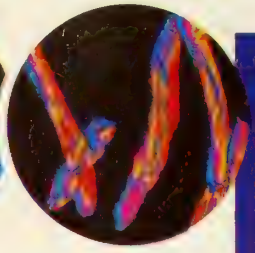
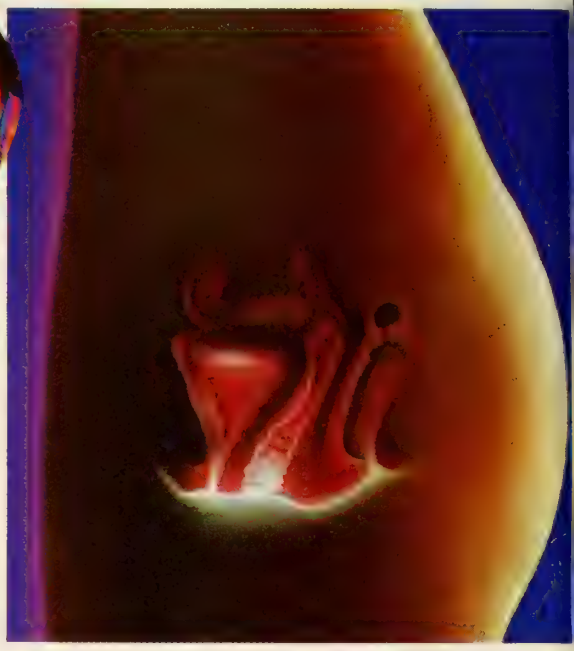
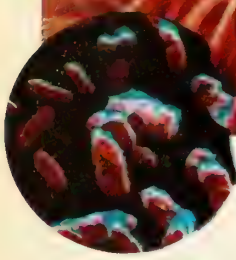


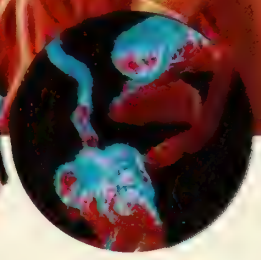


before *E. coli* culture—color-enhanced scanning electron microscopy (SEM).

after *E. coli* destroyed by Bactrim 5 × MIC *in vitro*. (*In vitro* data do not necessarily correlate with clinical results.)

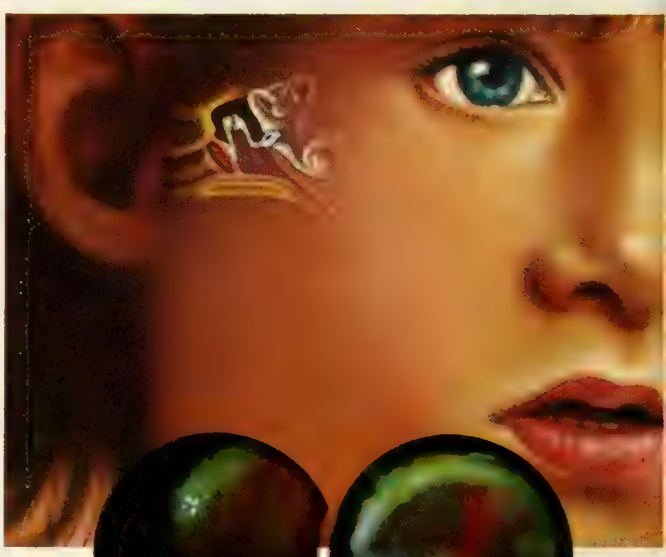


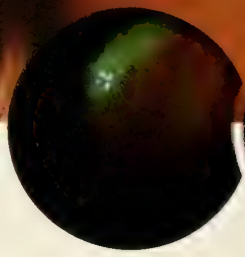




before *H. influenzae* culture—color-enhanced SEM.

after *H. influenzae* destroyed by Bactrim 5 × MIC *in vitro*. (*In vitro* data do not necessarily predict clinical results.)





before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

after Same patient after ten days of Bactrim therapy.

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Please see preceding page for a summary of product information.

Pennsylvania Medicine

Volume 88, No. 12 DECEMBER 1985

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Annual Meeting—page 12

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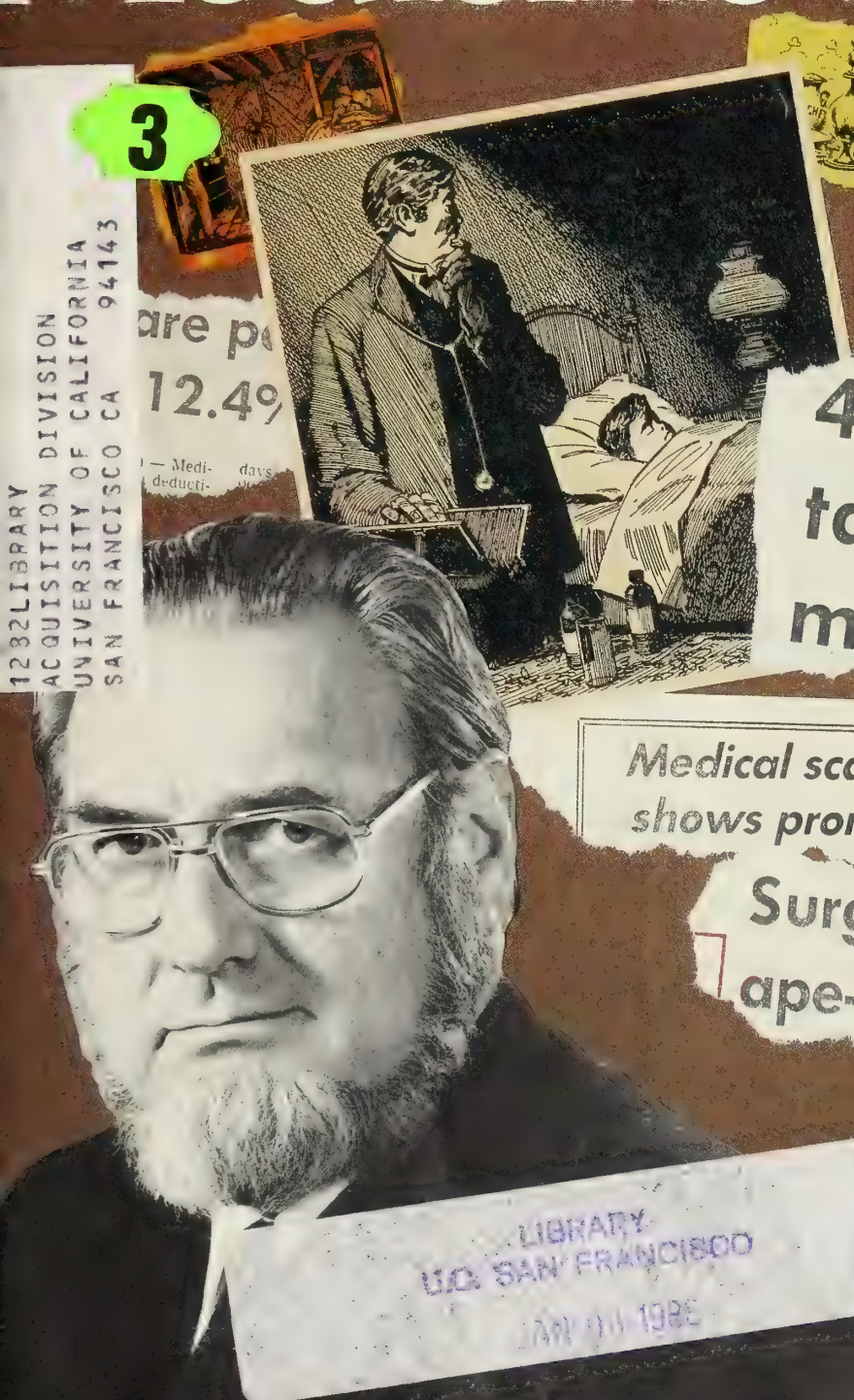

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Medical scanner with radiowaves shows promise but at a high cost

Surgeon defends ape-heart implant

VOCATION IN MEDICINE CHALLENGES AND SATISFIES

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References: **1.** Kales J, *et al: Clin Pharmacol Ther 12* 691-697, Jul-Aug 1971. **2.** Kales A, *et al: Clin Pharmacol Ther 18*.356-363, Sep 1975 **3.** Kales A, *et al: Clin Pharmacol Ther 19*.576-583, May 1976 **4.** Kales A, *et al Clin Pharmacol Ther 32* 781-788 Dec 1982 **5.** Frost JD Jr, DeLucchi MR *J Am Geriatr Soc 27*.541-546, Dec 1979 **6.** Dement WC, *et al Behav Med*, pp. 25-31, Oct 1978. **7.** Kales A, Kales JD: *J Clin Psychopharmacol 3*.140-150, Apr 1983 **8.** Tennant FS, *et al:* Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984 **9.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21* 355-361, Mar 1977

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants An additive effect may occur if alcohol is consumed the day following use for nighttime sedation This potential may exist for several days following discontinuation Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving) Potential impairment of performance of such activities may occur the day following ingestion Not recommended for use in persons under 15 years of age Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time Use caution in administering to addiction-prone individuals or those who might increase dosage
Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia Consider potential additive effects with other hypnotics or CNS depressants Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function
Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported Also reported headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity
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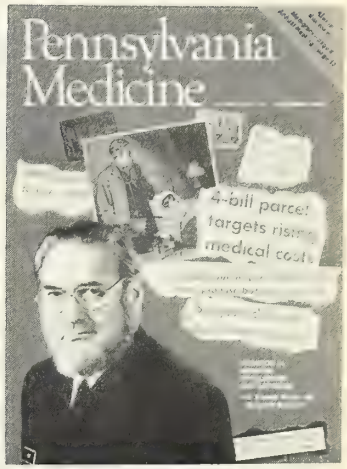

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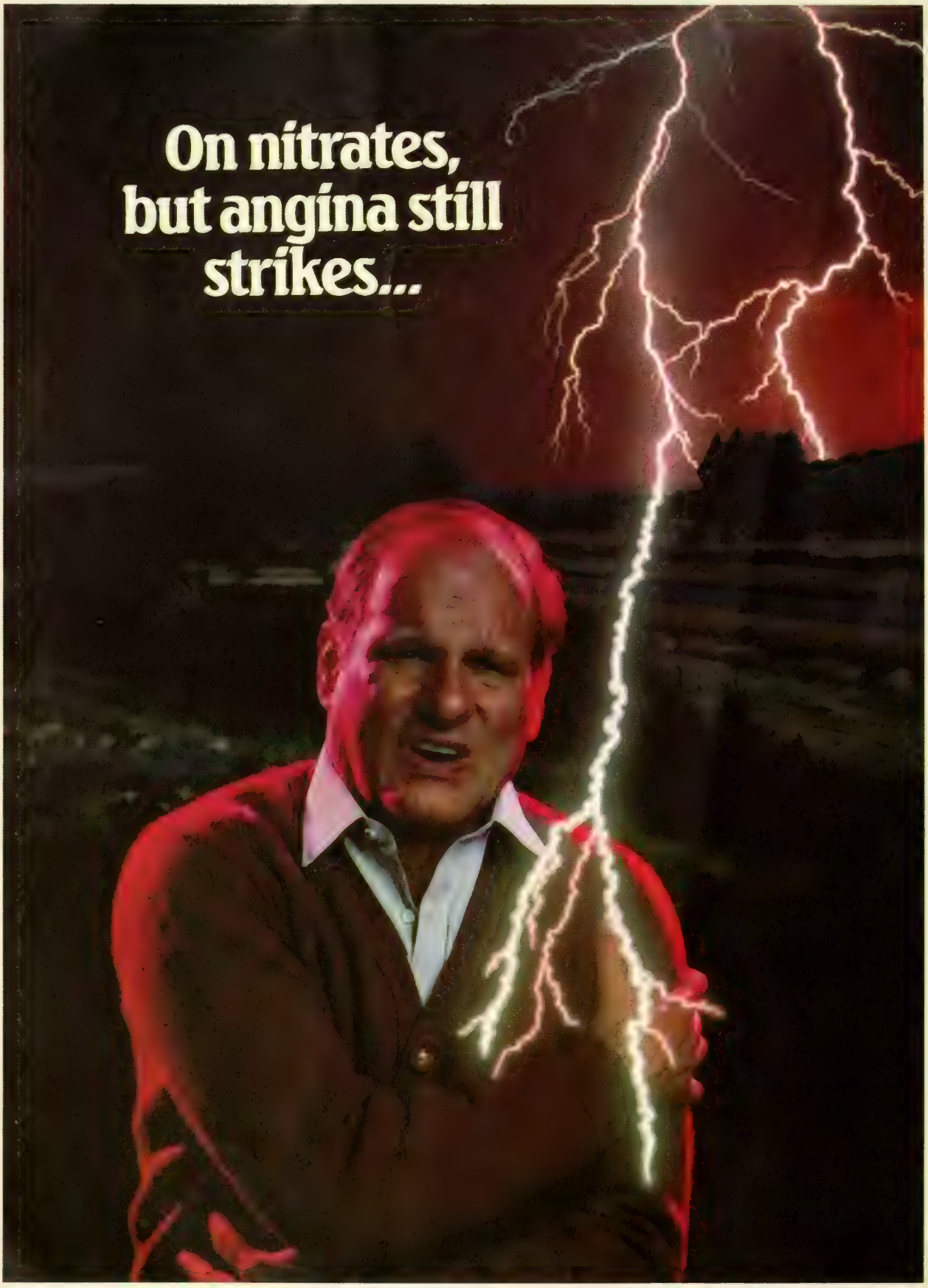
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Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. 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One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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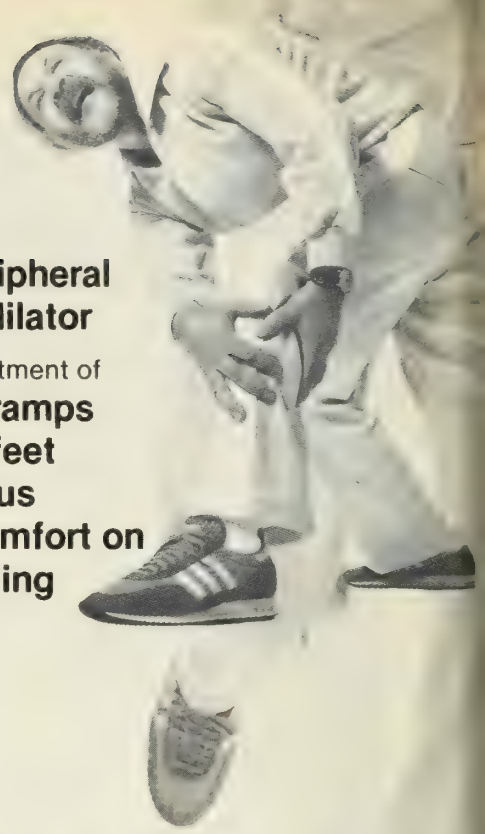

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DR. ALEXANDER URGES MEMBER PARTICIPATION

In his first letter to the membership, R. William Alexander, MD, PMS president, encouraged members to give full support, both financial and personal, to the public education program adopted by the 1985 House of Delegates. The mandatory special $55 a year assessment to fund the program appears on 1986 dues billings. The campaign will be launched statewide in January 1986 with newspaper and radio announcements.

PITTSBURGH SURGEON KEPRO MEDICAL DIRECTOR

Edward E. Longabaugh, MD, of Pittsburgh, began his duties as medical director of the Keystone Peer Review Organization (KePRO) in November. KePRO, a wholly owned subsidiary of the Pennsylvania Medical Society, is under contract with the Health Care Financing Administration to perform quality and utilization review of hospital admissions under the Medicare prospective payment system. A general surgeon, Dr. Longabaugh oversees the physician component of the review process and advises on matters pertaining to physicians.

PMS CONTINUES NEGOTIATIONS

The Society's negotiating team, with the approval of the 1985 House of Delegates, is continuing to meet with its counterparts from the Hospital Association of Pennsylvania and the Pennsylvania Trial Lawyers Association to find a solution to the professional liability insurance crisis in Pennsylvania. In authorizing the negotiations, as suggested by Senator Robert Jubelirer, president pro tempore of the Senate, the House of Delegates set a deadline of December 9.

GOVERNOR PROPOSES PLAN TO CONTAIN HEALTH COSTS

Another plan to contain the cost of medical care has been introduced. Governor Dick Thornburgh offered his proposal on October 29. Four areas are featured: 1) a temporary cap on capital expenditures; 2) a prospective payment system for Blue Cross; 3) additional utilization review mechanisms; and 4) the formation of a special committee to oversee the collection of information on costs. The governor called on all interested parties to work on a comprehensive package. He said the cost of medical care is still double the inflation rate (medical care rose 6.4% in fiscal year 1985; the overall consumer price index rose 3.2%).

SENATE AMENDS, PASSES MEDICAL PRACTICE ACT

The state Senate on November 20 passed the Medical Practice Act of 1985, the "sunrise" legislation for a State Board of Medicine. The PMS-supported bill, S.B. 1158, awaits action in the House of Representatives. Also passed by the Senate and sent on to the House for action were bills reauthorizing the licensing boards for podiatry, osteopathy, nursing, and practical nursing, which were among the professional licensing boards under sunset review in 1985.

SENATE PASSES LEGISLATION MANDATING SEAT BELT USE

The state Senate on October 29 adopted a bill strongly supported by the medical community which requires drivers and front seat passsengers in automobiles to use their seat belts. The legislation took the form of an amendment to S.B. 483, which concerns increased penalties for illegally parking in spaces reserved for the handicapped. The amendment on seat belts imposes a fine of $20 on those who do not buckle up. The bill awaits action in the House.

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editorial

Creative application of science

Aristotle once said, "Even in medicine, though it is easy to know what honey, wine and hellbore, cautery and surgery are, to know how and to whom and when to apply them so as to effect a cure is no less an undertaking than to be a physician."

Most clinicians are familiar with, or at least aware of, the rigid tests to which drugs must be subjected prior to marketing. Even these careful studies do not always reveal all of the harmful effects that may develop. Thalidomide is a good example. The reverse is also true. There may be beneficial uses that are discovered after release, but many of these findings remain unapproved. The administration of an approved drug for an unapproved therapy is neither forbidden nor sanctioned.

Pre-marketing research by pharmaceutical companies, based on scientific laboratory experience and studies on animals and humans, precedes the specific determination of drug usages. Controls are set and human experimentation closely monitored. The results of this research appear on the label or package insert under such subheadings as indications, hazards, toxicity, route of administration, dose, safety in pregnancy, and contraindications. The Food and Drug Administration then approves the "official" drug detail submitted by the manufacturer if such approval is warranted. The FDA approves the *accuracy of the label.*

The list of uses does not prohibit additional unapproved therapeutic applications. The FDA notes that the Food, Drug and Cosmetic Act "does not limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens on patient populations that are not included in the approved labeling." Thus, clinical use may be made of a drug for unapproved indications and the physician is free, within reason, to use judgment and initiative concerning the labeling information and other applicable data.

The question of why certain acceptable indications remain "unapproved" begs to be addressed. The explanation is twofold, economic and technologic. Drug companies, operating on a profit motive, are reluctant to pursue the tedious and expensive clinical trials to obtain additional approvals when the agent is already approved. Patents expire rather quickly and additional approvals are not always sufficiently remunerative to cover the additional expense of further requirements. It is generally acknowledged that medical technology advances rapidly and therapeutic innovations are relatively fast paced. For example, calcium channel blockers are already being tried for treatment of mild to moderate hypertension and also may be effective in the treatment of migraines. The FDA recommendations lag behind these other indications because the approval process is slow and is acted upon when clinical data and paperwork are submitted.

A number of opinions have appeared over the years concerning the liability of prescribing approved drugs for unapproved uses. Although there is no prohibition, physicians must weigh the risks of using the drug against benefits to the patient and exercise extreme caution. Clinicians should not alter prescribing habits because of pressures exerted by the lay press, e.g. cyclosporin for AIDS. Traditional standards of care apply when determining negligence in the use of drugs. Ignoring life-threatening side effects or toxicities already on the approved label is irresponsible. On the other hand, applying a drug in a way or in doses not detailed in the package insert but as may have been reported in current journal literature, clinical conference, expert consultation, or textbook normally would be acceptable.

The importance of informed consent in these kinds of situations cannot be overemphasized. The Patient Package Insert (PPI) and the *Physicians Desk Reference* (PDR), the two most likely sources of information to a patient, do not include "other" uses. Sources more likely to be consulted by a physician, such as the *AMA Drug Evaluations* or the *American Hospital Formulary Service Drug Information,* do contain such information. The physician's familiarity with "other" indications does not mean that the patient also will have this knowledge. Many physicians believe that some of the "other" indications are approved when they really are not.* It is very important to mention the "unapproved" use and dose of a prescribed medication, especially if the packing slip does not include directions.

"Nor has Rhubarb prov'd always a purge, or opium a soporific to everyone who has taken these medicines," wrote David Hume, Scottish philosopher and historian. The use of approved drugs in unapproved ways is a common practice in the medical profession. These therapeutic applications may be justified by scientific foundation and may be the standard of care for the community. In fact, these digressions from approved channels are probably one of the remaining temples of the art of healing. "Like all great art, the art of medicine is the skillful and creative application of a scientific discipline to a human problem. The musician without harmony, the painter with no knowledge of pigment and perspective, the architect unaware of the essential elements of engineering—are all amateurs, as is the physician unversed in the science of medicine, its methods of thought, and its accumulated facts."**

David A. Smith, MD
Medical Editor

*Erickson, SH; Bergman, JJ; Schneeweiss, R; Cherkin, DC: The use of drugs for unlabeled indications. JAMA, 243 (15): 1543-1546.

**Atchley, Dana W. *Journal of Medical Education.* 34: 17, 1959.

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Society's priorities set for 1986

Karen K. Davis

The need for equitable reforms in the current medical liability system was a dominant issue at the Society's 1985 Annual Meeting, held October 25-27 in Philadelphia. Also at that meeting, the House of Delegates adopted measures affecting the structure of the Society, and took action in the areas of public education, impairment, relationships with third party payers, medical education, public health, and laboratory testing.

Professional liability

In the area of professional liability reform, delegates adopted a recommendation of the Task Force on Professional Liability Insurance that three representatives be appointed and authorized to continue negotiations through Senator Robert Jubelirer's Select Committee on Medical Malpractice. The House established December 9, 1985, as the deadline for reaching agreement on a legislative package. If the negotiations are not successful by December 9, the Society will introduce its own legislation.

The House discharged the task force, and established in its place the three member committee, appointed by the president. Physicians assigned to the new committee are: John Y. Templeton, III, MD, task force chairman; John W. Lawrence, MD, from the Council on Legislation; and Donald E. Harrop, MD, vice president, representing the Board of Trustees.

Delegates voted to sponsor a one day mass meeting between physicians and legislators, to be scheduled at the appropriate time in 1986, in support of the Society's proposals.

The House adopted a resolution calling for the Society to examine and put to use methods that proved helpful in achieving equitable solutions to professional liability problems in other states. Physicians referred to the Board of Trustees a proposal that the Society set up a Liability Initiative Program and organize action teams to demonstrate and disseminate literature on the liability crisis. Also referred for study was a resolution calling for review of malpractice cases by special committees.

Bylaws changes

The House of Delegates considered a number of items related to the make-up of the Society's Board of Trustees. The House adopted a bylaws change abolishing the position of the PMS secretary and providing for the election of a secretary from the Board to serve as secretary for the Society. John H. Hobart, MD, Easton, Third District Trustee, was elected to the new position at the reorganizational meeting of the Board. Delegates also approved a bylaws change making the specialty trustee eligible for election as chairman of the Board. In addition, physicians voted to amend the bylaws to seat a representative of the Hospital Medical Staff Section as a voting member of the Board of Trustees.

DR. HARROP

The House instructed the Committee on Bylaws to develop appropriate language that would limit Board eligibility to full dues-paying, active members of the Society, with the exception of residents and students. The House retained current requirements for holding the office of chairman of the Board, and also approved the recommendation that the president, past president, president elect, vice president, and the speaker and vice speaker of the House continue to be voting members of the Society's Board of Trustees. The recommendation to reduce the number of district trustees and to redefine the districts was rejected. Referred to the Board for study was the recommendation that a nonvoting, ex officio position on the Board go to a representative from the PMS Auxiliary.

The House charged the Committee on Bylaws to develop language on two other issues. Delegates asked that language be drafted to reflect the actual process used for approval of loan distribution to medical students. The present practice is for the Committee on Aid to Education to approve block grant allocation of funds to the medical schools for distribution based on specific criteria established by the Society's Educational and Scientific Trust.

Delegates ordered a bylaws change to allow a physician member from the same councilor district to fill a vacancy if a county medical society lacks a delegate or alternate delegate at a meeting of the House. The physician filling the vacancy must have the approval of the president or secretary of the component county society for which he is being seated.

Public education campaign

The House endorsed the implementation of a statewide public education campaign, and gave the Board of Trustees the authority to allocate expenditures proportionate to the importance of priorities. The House also approved the recommendation that the program be funded by a three year mandatory assessment of $55 per year for full dues paying members.

Dues for active members will remain at $275. Of that amount, a 4.44 percent allocation ($10) will go to the Educational and Scientific Trust for maintenance of the student loan program. The special mandatory payment of $55 will be charged to full dues-paying members and a proportionate amount to other members to fund the Society's public relations program.

Delegates voted to fund the full cost of the Society's impaired physician pro-

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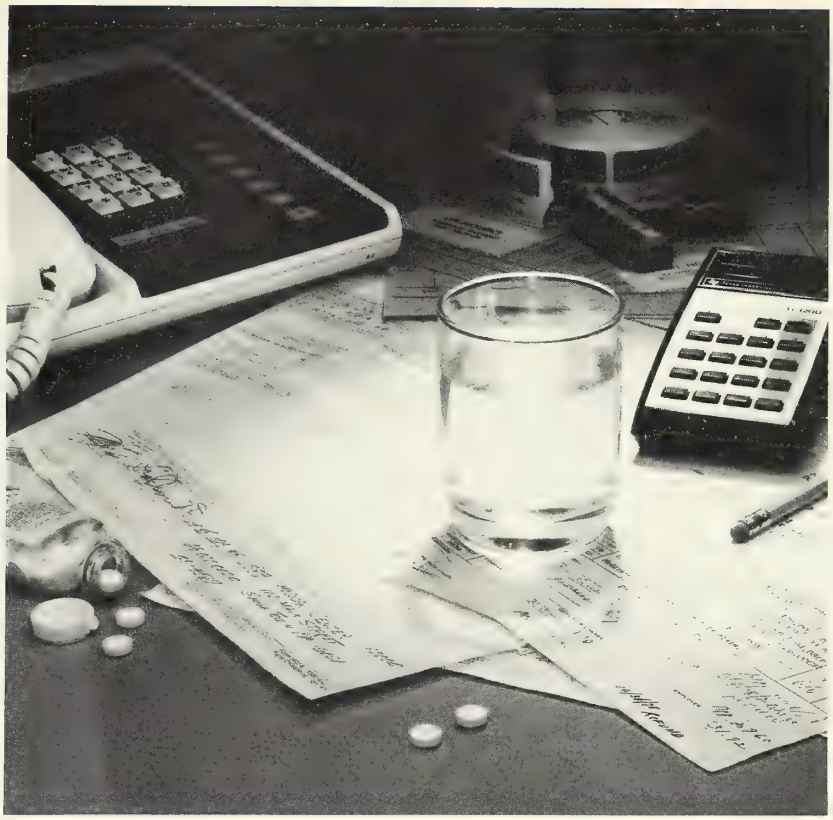

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gram less any contributions from outside sources. The program has been expanded to include a full-time medical director.

Third party payers

Several issues concerned third party payers. Delegates supported legislation that would remove Blue Shield and Blue Cross from special status so that these companies would be treated in the same manner as other health insurers in Pennsylvania. Also, delegates voted to lobby for regulations that would require insurance companies doing business in state to make direct payment to physicians based on the patient's agreement to an assignment of the claim. The House resolved that the Society should support the development of a uniform system for the evaluation of possible fraud and misutilization by physicians, for the use of third party payers.

The House voted to defend the physician's right to balance bill patients who are financially able to make up the difference between a third party payment and a reasonable price for services rendered. Delegates also agreed to petition third party carriers in the state to allow for reasonable remuneration for the time involved in the supervision of patients receiving home care after hospitalization.

The House adopted a resolution asking the American Medical Association, in discussions with the government and other third party payers, to assert the position that medical education is an integral part of hospital care and that the direct and indirect costs of medical education should be supported by third party payers. A resolution calling for the Society to oppose interference with patient management and stating that prospective and retrospective chart review must not supersede on-site physician judgment was approved. Also recommended was a system to monitor the potential savings and detrimental effects of precertification of elective hospital admissions.

The House asked the Board to study the recommendation that the Society lobby for regulations that allow uniform reimbursement for all providers for the technical components of procedures. Delegates ordered the development of a policy that attending physicians be provided, on request, with a patient's itemized bill for hospitalization. The House also called for amendment of the Department of Health's regulations on health and safety to permit free access to providers in health maintenance organizations (HMOs).

Medical education

Delegates considered several items dealing with medical education. The Board will study resolutions that ask the Society to lobby to establish funding programs to allow financing, through direct support payments or through loan programs, for undergraduate and graduate medical education of citizens of Pennsylvania. Also referred for study was the recommendation that medical schools be asked to freeze tuition at current rates and the resolution that calls for the Society to support legislation on financial aid issues.

Public health

Physicians voted on several public health issues. They referred to the Board for consideration a recommendation that the Society lobby for legislation to amend the current laws so that driving with a blood alcohol level greater than .05 percent is a crime. Also referred to the Board for study was a resolution calling for the Society to lobby for legislation to prohibit corporal punishment in the state's schools. Physicians supported the development of right to die legislation that will protect the rights of the patient, the family, and the physician to make decisions in this matter. The House voted to support legislation before the Pennsylvania General Assembly that provides for a regional isolation facility for low level radioactive wastes.

Drugs and tests

Physicians voted support for legislation to establish a prescription monitoring system to fight the problem of illegal traffic in prescription drugs in Pennsylvania, and they supported the development of a program to evaluate and compare generic products and their brand name counterparts in order to reduce the risks to patients using inferior drug formulations.

The House voted to promote the use of physicians' office laboratories as a way to provide laboratory testing to patients in an efficient, accurate, and cost-effective manner. Delegates gave support to legislation to abolish mandatory premarital serological test for syphilis in Pennsylvania. The House asked producers of vaccines to moderate prices for mandated vaccines, and voted to support efforts by pharmaceutical companies to reform product liability laws. A resolution asking the state Department of Health to establish a policy on alpha-feto-protein testing for Medicaid patients was referred to the Board.

In other actions, the House resolved to oppose HB-1304, which would mandate disclosure of questions, answers, and other test materials to anyone taking an occupational test, including medical specialty and medical licensure examinations. Physicians indicated their dissatisfaction with the Deficit Reduction Act of 1984 and voted to ask the American Medical Association to appeal a lower court's dismissal of the association's suit against this act.

Delegates also authorized the Society to work to amend the Peer Review Protection Act so that it will preserve the confidentiality of the proceedings and records of peer review committees and forbid the use of these records as evidence in any civil action against a health care provider.

Complete proceedings of the 1985 meeting of the House of Delegates will be published in the January 1986 issue of PENNSYLVANIA MEDICINE.

CHILD FIND INC.
7 Innis Avenue New Paltz NY 12561

At its meeting on September 18, the Society's Board of Trustees authorized the publication in PENNSYLVANIA MEDICINE of photographs of missing children. It is hoped that publication of the missing children's pictures may help in the return of these children to their legal homes.

Missing: Tori Rochelle Ward
Born: 2/2/78
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*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

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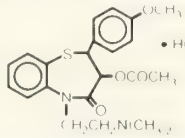
DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence:

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

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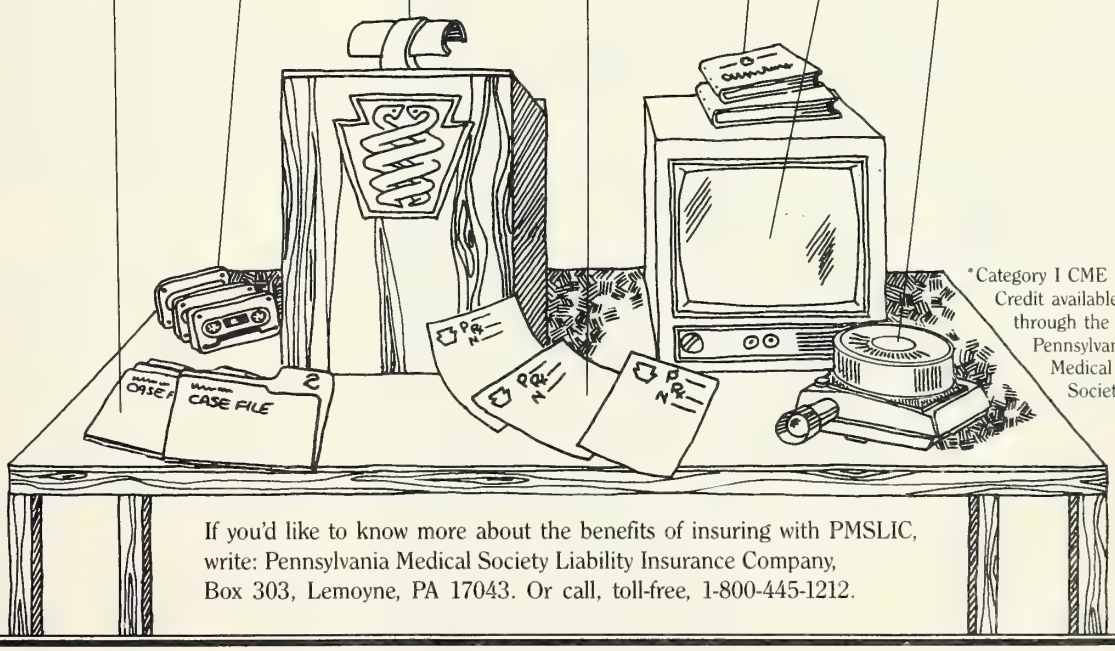

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Dr. Alexander lists priorities for action

In his inaugural address at the opening session of the 1985 meeting of the PMS House of Delegates, Society President R. William Alexander, MD, touched on several themes that dominated this year's session of the House. He spoke about cost containment, public relations, and medical liability issues. A radiologist from Reading, Dr. Alexander became the Society's 136th President at the meeting, held October 25-27 in Philadelphia.

Dr. Alexander urged delegates to "accept the changing environment surrounding the practice of medicine." He cited the example of Philadelphia General Hospital, the oldest medical care facility in the original colonies, which was closed due to cost concerns. "That instance, in which a revered, historic teaching facility was closed by the government based on the cost to operate that facility, is a familiar example of the tremendous changes being wrought in the name of cost efficiency," he said, adding that physicians must adjust to multiple forces requiring new relationships with patients, hospitals, government, and third party payers.

"We cannot expend our resources nostalgically, longing for the past or fighting futile battles," he continued. "We must allocate our time and financial commitments to see that above all else, only quality medicine is made available to our patients." He challenged the delegates and those they represent to continue to reach out to their patients, giving time and attention, and "carefully explaining their problems, what can be done, and what the expected outcomes may be."

Dr. Alexander said figures from a public awareness survey conducted by the American Medical Association showed that people in Pennsylvania rank physicians higher than the national average in accessibility, interest in patients, treating the poor and elderly, establishing reasonable fees, and spending time with patients. On the other hand, he said, the survey also showed people in the state perceived that physicians "don't care about people as much as they used to." Of Pennsylvanians surveyed, 41 percent complained about excess waiting time in the office, he said. "This concern far exceeds complaints about cost—the cost of the visit concerned only 14 percent of those surveyed."

Other studies show people trust their individual physicians, but distrust physicians as a group, Dr. Alexander said, and "this situation suggests the solution to the problem." He advised the House to take group action to educate the public about current health care matters by putting the proposed public relations program into effect, and to take action on an individual basis by allotting more time for personal contact and discussion with patients.

Dr. Alexander also spoke about the "lingering concern of medical liability." He asked the House to accept the legislative plan of the Society's Task Force on Professional Liability Insurance, which recommends that the Society's president should appoint three physicians to a committee and authorize them to conduct negotiations with other interested parties through Senator Robert Jubelirer's Select Committee on Medical Malpractice. The report also recommended that the three-member committee oversee implementation of the Society's own legislative package in case the Select Committee has not reached agreement on a package by December 9. "This plan appears to be a realistic approach to a critical problem," Dr. Alexander said.

The new president also recommended the House authorize funds to initiate the Society's program to identify and rehabilitate impaired physicians. "We need to reach out to our fellow physicians whose medical effectiveness has been impaired. We all benefit when we help these physicians return to a useful life," he said.

Dr. Alexander recommended a continuation of the communication, started by Immediate Past President D. Ernest Witt, MD, with leadership of senior citizens groups, business, labor, hospitals and insurance carriers. Such liaison provides beneficial ties for each of the organizations involved, and allows us to formulate common bonds with our natural allies, he said.

Finally, Dr. Alexander requested that the House formally instruct the Board of Trustees to bring together the leaders of the Society's administrative councils and commissions "for the purpose of identifying goals, programs, and materials available to each. In this way," he said, "the overall activities of the Society can be better understood by each part and the overlapping of functions can be corrected."

Copies of Dr. Alexander's address are available on request from the Pennsylvania Medical Society.

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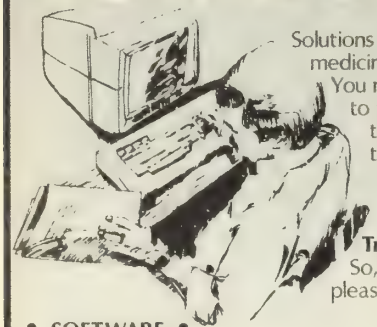

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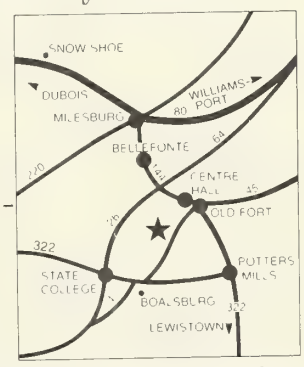

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Dr. Witt recounts events of note in 1985

In his farewell address to the PMS House of Delegates, President D. Ernest Witt, MD, reviewed a year of progress maintaining quality in the health care delivery system, working for liability insurance reform, and increasing membership.

In the area of health care delivery, Dr. Witt said that "while financing mechanisms will change, the basic precepts of the doctor-patient relationship—rapport, concern, and caring—must prevail. Quality of care must be maintained no matter what cost framework finally evolves."

He said meetings with leaders of groups such as the Hospital Association of Pennsylvania, Blue Cross, Blue Shield, the AARP (American Association of Retired Persons), and representatives of the underinsured and unemployed have "started dialogues that may lead to the solution of some of the current problems."

Health care cost control has been an important subject for discussion because of the push for legislation in this area, Dr. Witt said. He reviewed the August and September hearings of the Health and Welfare Committee of the House of Representatives, at which R. Robert Tyson, MD, president elect of PMS, testified on behalf of the Society. "In the months ahead, I am sure that serious negotiations on state health care cost control legislation will occur;

however, PMS has been established as a key player in this drama and will work for responsible legislation that preserves physicians' freedom to practice quality medicine," he said.

"The Medical Practice Act became a priority issue this year, because of its review under the sunset mechanism," Dr. Witt continued. "To manage this priority, a task force was created by the Board of Trustees. Its job has been to assure that the final bill reflects the principles adopted by this House of Delegates last year, and I believe there is every reason to expect the Act, when finally signed, will embody the principles we seek."

Dr. Witt said that after four years of struggling to find answers to the professional liability insurance problems, there is now hope that the crisis will be recognized and meaningful legislation can be drafted.

Dr. Witt reported that the Council on Membership recorded the following net increase for 1984: Active members increased by 274; students by 127; and residents by 260. "Through our membership gain we have earned an additional delegate to the AMA (American Medical Association)," he said. He urged all members of the House and those they represent to join the American Medical Association, and to become sustaining members of PaMPAC and AMPAC (the Pennsylvania and American Medical Political Action Committees).

Dr. Witt also summarized other actions the Society took during the year:

- The Committee on Organization and Operation of the Board of Trustees developed a written protocol of Board rules and operations, which was adopted by the Board.
- The Long Range Assessment Committee has presented its first report and will continue to report to the Executive Committee of the Board, which now is responsible for planning.
- Lobbying and negotiations have produced improvements in the Medical Assistance program. On April 1, the Medical Surgical Fee Schedule was increased to 50 percent of statewide average usual charges, and on October 1, the Medicaid program began to reimburse physicians at 70 percent of the statewide average usual charges for office visits.
- PMS has become a participant in the call for mandatory seat belt legislation, which has passed the Senate and awaits action by the House of Representatives.

In closing Dr. Witt said, "Our goals as individual practicing physicians must be to support organized medicine, to assist in improving the legislative process, and to continue to practice cost effective, quality medicine, with concern and caring for our patients."

Copies of Dr. Witt's speech are available from PMS on request.

Book examines hospital, medical staff dynamics

William R. Fifer, MD, whose articles have appeared in PENNSYLVANIA MEDICINE, is one of the authors of a new book, *The Medical Staff and the Modern Hospital*, which focuses on current changes health care field. The book has been described as "a stop-action photograph of the kaleidoscopic world of medical staffs and their hospitals." It deals with interactions, conflicts, and dependencies of both hospitals and the physicians who use them and serves as a guide to help institutions adapt in present and future environments.

Dr. Fifer wrote the text with his colleagues C. Wesley Eisele, MD, and Toma C. Wilson, MPA. The work was published by Estes Park Institute, Englewood, Colorado.

Dr. Fifer spent 15 years as an internist in a multispecialty group practice, and ten years in medical education and health services at the University of Minnesota, where he is clinical professor of medicine and public health. He has served as a consultant to the JCAH (Joint Commission on Accreditation of Hospitals), the American College of Hospital Administrators, and the federal Department of Health and Human Services. He is president of the consulting firm Clayton, Fifer Associates. Among articles Dr. Fifer has written on the evaluation of medical care for PENNSYLVANIA MEDICINE are "Prospective payment startegy—is it working," (December 1984) and "Is rationing of medical care inevitable?" (November 1985).

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PMS House of Delegates elects new leaders

The Society established a new chain of command at its annual business meeting held October 25-27, 1985, in Philadelphia. The House of Delegates elected Donald E. Harrop, MD, a general practitioner from Phoenixville, vice president of PMS. He will succeed to the presidency in 1987. Also at the October meeting, R. William Alexander, MD, Reading, was installed as president, and R. Robert Tyson, MD, Philadelphia, succeeded to the office of president elect.

Dr. Harrop received his medical degree from the University of Pennsylvania School of Medicine and served an internship at Presbyterian Hospital, Philadelphia. He spent two years as a captain in the U. S. Army Medical Corps at the Army hospital in Landstahl, Germany. He is chief of the department of general practice at Phoenixville Hospital and is Chester County coroner, a position he has held since 1966.

On the local level, Dr. Harrop has served as secretary of Chester County Medical Society. He has been the volunteer physician for Phoenixville Area High School's athletic teams for the past 28 years, as is past president of Community Services for Human Growth, the local mental health service.

Dr. Harrop also has been active at the state level, serving as speaker of the PMS House of Delegates from 1982 to 1985, and as vice speaker from 1976-1982. He served as chairman of the Council on Governmental Relations and the Commission on Forensic Medicine. He is one of the original directors of PMSLIC (Pennsylvania Medical Society Liability Insurance Company), as well as a current member of the company's board, and a past chairman of PMSLIC's claims committee. Dr. Harrop is president of KePRO (Keystone Peer Review Organization), the Society's subsidiary formed this year which successfully bid to become the Medicare Peer Review Organization in Pennsylvania. Dr. Harrop is a past president of the Pennsylvania State Coroners Association and a past president of the International Association of Coroners and Medical Examiners.

Delegates also elected six trustees: Walter M. Greissinger, MD, Pittsburgh, to represent the Tenth District; Victor F. Greco, MD, Drums, to represent the Twelfth District; and Jeannine R. Hahn, MD, to represent the Resident Physician Section. Delegates reelected three other trustees: Betty L. Cottle, MD, Hollidaysburg (to represent the Sixth District); Irving Williams II, MD, Lewisburg (to represent the Seventh District); and Martin A. Murcek, MD, (to represent the specialty societies).

Dr. Greissinger, a family physician, received his medical degree from the University of Erlangen in his native Germany, and also has a master's degree in public health from Johns Hopkins University. He has worked to raise the state's Medicaid reimbursement of physicians from 20 percent of usual fees to 70 percent. In 1985 Dr. Greissinger served as president of the Pennsylvania Medical Care Foundation.

Dr. Greco, a general and thoracic surgeon, received his medical degree from Jefferson Medical College of Thomas Jefferson University. He has been active in organized medicine, and at the state level he served as vice chairman of the Council on Medical Economics and chairman of the Subcommittee for Blue Cross and Blue Shield Relations. He also has been a Board member of the Pennsylvania Medical Political Action Committee.

Dr. Hahn earned her medical degree from Hahnemann University School of Medicine and currently is serving a residency in general surgery at Abington Memorial Hospital. Chairman of the Resident Physician Section, she also has served as member-at-large on the Resident Physician Section's Governing Council and as a delegate to the American Medical Association.

James A. Raub, MD, Sewickley, was elected speaker of the House, and Jonathan E. Rhoads Jr., MD, Philadelphia, was elected vice speaker.

Dr. Raub, an obstetrician and gynecologist, graduated from Hahnemann University School of Medicine. He served as president of Blair County Medical Society, and since moving to Sewickley, has held various positions in the Allegheny County Medical Society. He served as vice speaker of the House for three years prior to his election as speaker this year.

Dr. Rhoads graduated from Harvard Medical School and is a general and thoracic surgeon in York. He currently serves as chairman of the Society's Council on Membership, and is a member of the Task Force on Public Policy Aspects of Competition. He is an alternate delegate to the American Medical Association, and a member of the AMA's Ad Hoc Committee on Young Physicians.

Michael P. Levis, MD, Pittsburgh, and Joseph M. Stowell, MD, Altoona, were elected to the Society's Judicial Council. Three physicians were elected

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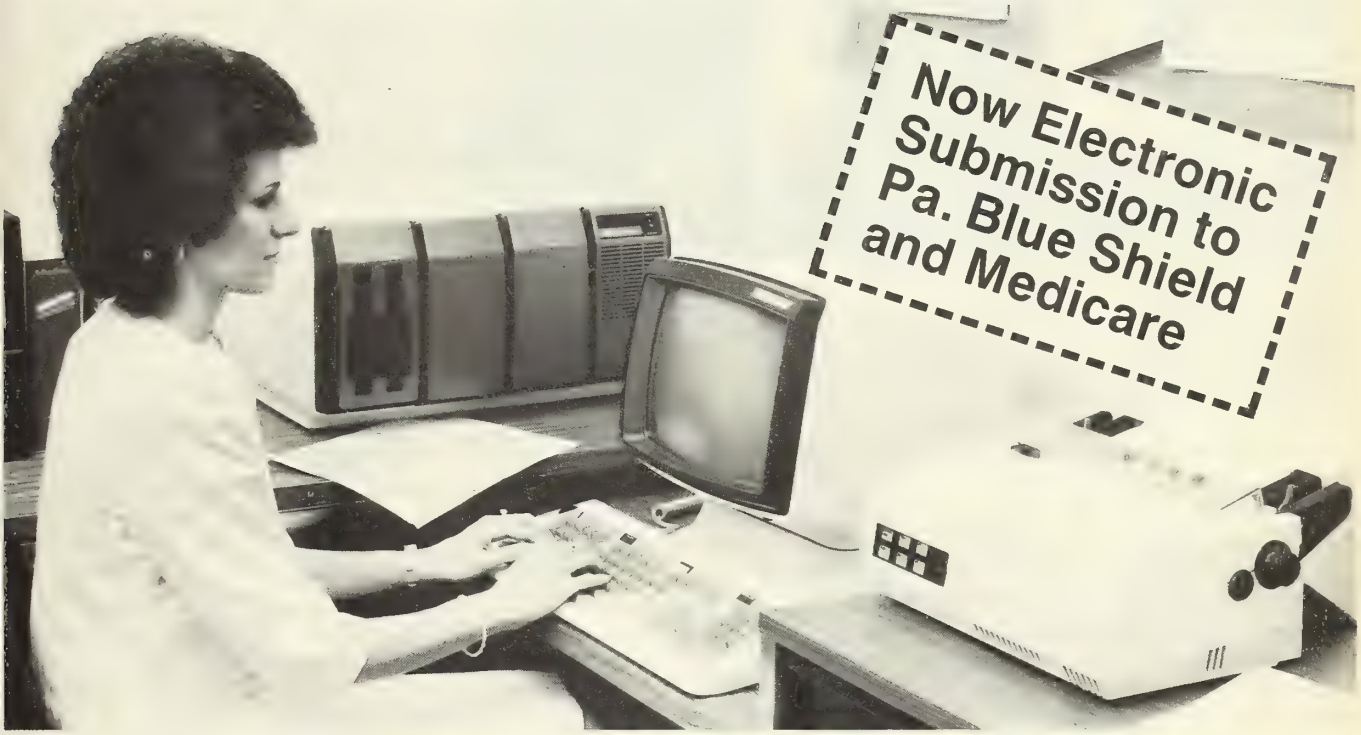

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to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. They are: Thomas J. Kardish, MD, Southampton; Richard P. Kennedy, MD, East Stroudsburg; and Brooke Roberts, MD, Philadelphia.

The House reelected eight delegates to the American Medical Association for two year terms. They are: Gerald L. Andriole, MD, Hazleton; Robert J. Carroll, MD, Pittsburgh; Joseph N. Demko, MD, Dunmore; Henry H. Fetterman, MD, Allentown; George R. Fisher III, MD, Philadelphia; Matthew Marshall Jr., MD, Pittsburgh; Robert N. Moyers, MD, Meadville; and R. Robert Tyson, MD, Philadelphia. In addition, Donald E. Parlee, MD, Doylestown, was elected a delegate to the AMA for a one year term.

Eight alternate delegates to the AMA were chosen for two year terms. The House elected Mary C. Barton, MD, Hershey; Doris G. Bartuska, MD, Philadelphia; Joseph B. Blood, MD, Sayre; Donald C. Brown, MD, Irwin; Alan H. Schragger, MD, Allentown; Barbara Shelton, MD, Philadelphia; Donald H. Smith, MD, Easton; and William J. West, MD, Carlisle. Also elected were Charles A. Heisterkamp III, MD, Lancaster, and William H. Mahood, MD, Abington, to one year terms as alternate delegates to the AMA.

J. Joseph Danyo, MD, York, was elected chairman of the Society's Board of Trustees at a reorganizational meeting. Robert N. Moyers, MD, Meadville, was elected vice chairman and John H. Hobart, MD, Easton, was elected secretary of the Society.

An orthopedic surgeon from York, Dr. Danyo has been the trustee representing the Fifth District since 1980. He received his medical degree from Jefferson Medical College of Thomas Jefferson University. He is a past president of York County Medical Society and has been a member of the board of directors of the Pennsylvania Medical Care Foundation. He has served as vice chairman of the board of the Pennsylvania Medical Society Liability Insurance Company and is past chairman of the Council on Medical Economics.

A complete directory of the Society's officers and council and committee members will be published in the January 1986 issue.

Society honors Pittsburgh transplant surgeon

Pittsburgh transplant surgeon Thomas E. Starzl, MD, PhD, received the Pennsylvania Medical Society's distinguished Service Award—the highest honor given a member of PMS—on October 26 at a ceremony during the Society's annual business meeting in Philadelphia. Dr. Starzl was recognized for his work in establishing a successful liver transplant program at the University of Pittsburgh. He is the eleventh physician to receive this award, which was first presented to Jonas E. Salk, MD, in 1956.

Dr. Starzl described the award as "one of the nicest honors I have received because it is from the state where I live and from people that I work with. That's why it is a special honor for me." he said.

Dr. Starzl performed the first successful liver transplant in 1967 and has done nearly half the transplants performed since that time. In 1984, he performed the world's first successful heart-liver transplant.

DR. STARZL

Born and raised in LeMars, Iowa, Dr. Starzl earned his BA degree from Westminster College in Fulton, Missouri. He received his MA degree from Northwestern University, Chicago, and in 1952 was awarded his MD and PhD from the same university. He served an internship, residency, and fellowship in surgery at Johns Hopkins Hospital, Baltimore, and trained further at University of Miami School of Medicine and the Veterans Administration Research Hospital in Chicago.

Many organizations have honored Dr. Starzl for his surgical accomplishments. He was named Colorado's Man of the Year in 1967 and received Denver's Anthonian Award for Community Service in 1968. He was given the Fourth Annual Achievement Award of the Association of Veterans Administration Surgeons, and he received the Sheen Award from the American College of Surgeons. In 1981, he was named Pittsburgh's Man of the Year in Medicine, and in 1983 he was given a Super Surgeon Award by the children of Pittsburgh who have had liver transplants.

D. Ernest Witt, MD, who presented the Distinguished Service Award to Dr. Starzl, commended him for "his singular vision, perseverance, and dedication, and for taking the art of medicine to a new level by perfecting the techniques of kidney and liver transplantation."

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Allegheny CMS develops IPA/HMO

ACMS Executive Director H. David Moore, Jr., and PHPPA President Daniel H. Brooks, MD, welcome Larry Rambo, chief officer of the Physicians Health Plan of Pennsylvania.

Since January 1985, the Physicians Health Plan of Pennsylvania (PHPPA) has evolved from concept to reality through the impetus of the Allegheny County Medical Society.

Leaders cite the economic impact of such a plan on the health care system, the opportunity to influence change in the health care system, and the mechanism which an IPA/HMO provides for exerting physician control of health care while limiting increases in patient cost as the major reasons behind the formation of PHPPA, a physician owned and controlled prepaid health plan.

"Several but peripheral important benefits have accrued from the PHPPA development process," observed Daniel H. Brooks, MD, president of the Physicians Health Plan of Pennsylvania. First, 5,000 physicians in a five-county region have been exposed to and informed about prepaid care, HMOs, and IPAs. PHPPA has provided physicians with the opportunity to better understand the characteristics of prepaid care. More than 600 physicians attended the general meetings. The board of directors of PHPPA has continued to meet with specialty groups and medical staffs. The Allegheny County Medical Society (ACMS) has received and answered hundreds of telephone inquiries.

Second, every physician or group of physicians has had to assess its own practice, goals, and plans in order to decide whether or not to participate in PHPPA. "PHPPA has stimulated physicians to assess practice strategies, to begin to think about future practice patterns, and to prepare for the inevitable changes which are occurring in health care," Dr. Brooks noted.

Third, PHPPA has stimulated specialty groups to understand the changing nature of specialty practice and to assess the roles of particular specialties in prepaid plans. This is especially important in circumstances where a gatekeeper is mandated, as is the case in Pennsylvania. The PHPPA wil provide an excellent opportunity for continuing dialogue.

Fourth, primary care physicians have begun to organize their practices to provide for more extensive ambulatory care, to develop illness prevention programs, and to serve as the coordinators of a patient's health care in a more comprehensive way.

By October 15, 1985, 1,350 physicians had signed PHPPA participation agreements. The Credentials Committee has been reviewing applicants. Certification by the state insurance and health departments and licensure is in progress. The Securities and Exchange Commission approved the prospectus in September and stock subscriptions currently are being received. A number of preliminary contacts have been made with employers. It is expected that the plan will be operational in January 1986, when full-scale marketing will begin.

Larry Rambo was introduced as the chief executive officer of PHPPA on October 15 at the ACMS Business Meeting. He began full-time duties on October 21. The former executive vice president and chief operating officer of Methodist Health Systems, Memphis, Tennessee, he was responsible for development of alternative delivery systems, an ambulatory care system and a joint venture national referral laboratory. He pursued undergraduate and graduate studies at the University of Wisconsin, earning a master's degree in health services administration.

"With Larry Rambo on board we are embarking on an aggressive program to sell PHPPA," Dr. Brooks said.

"Through PHPPA, we have earned a place at a different level of negotiations in the health care industry. The opportunities are unlimited if physicians in western Pennsylvania continue to respond positively and work together as we provide high quality, prepaid health care in the open access freedom of choice mode," Dr. Brooks concluded.

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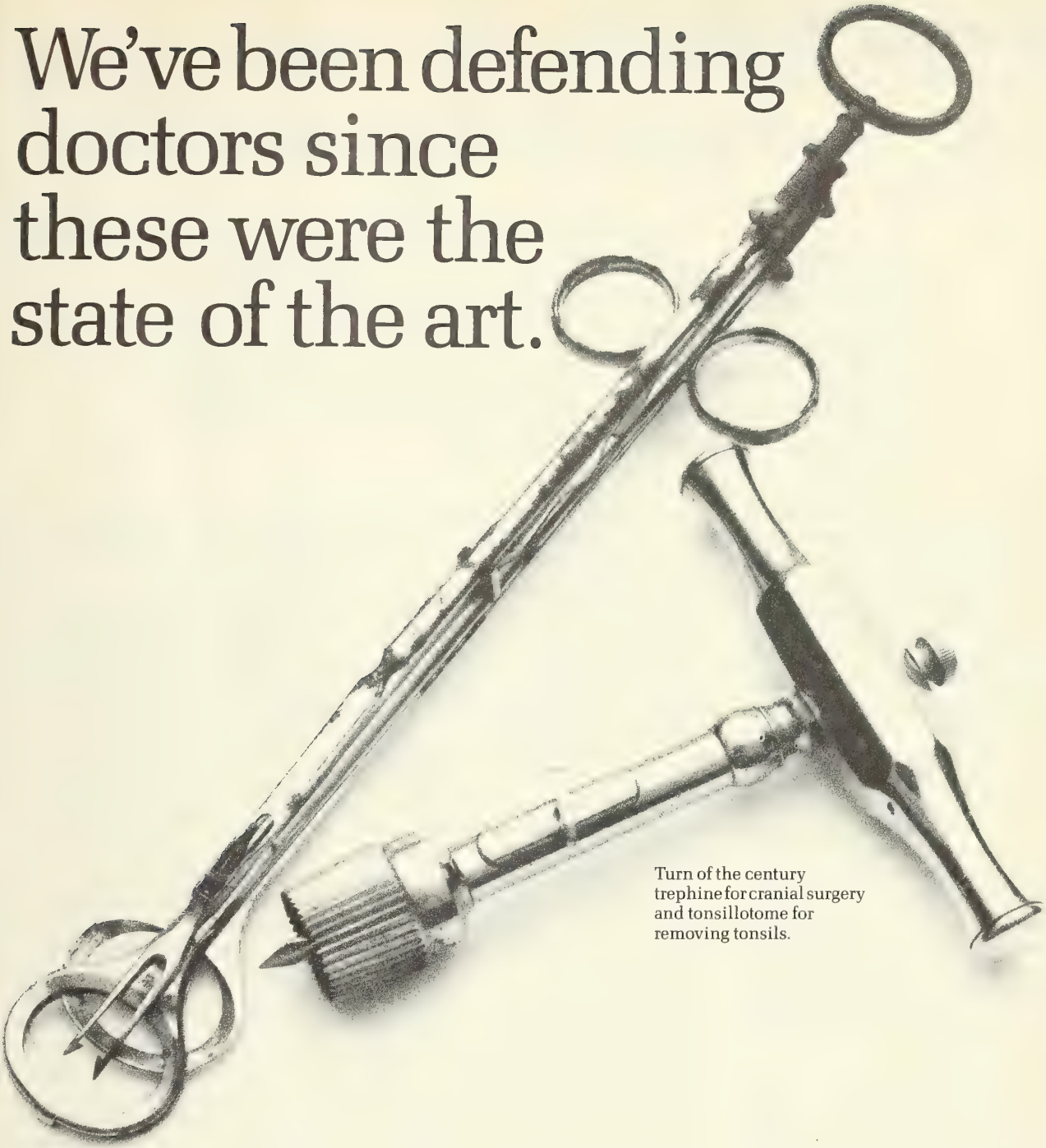

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special feature

Vocation in medicine challenges and satisfies

C. Everett Koop, MD

The Surgeon General of the United States returned last spring to Philadelphia, where he spent his medical career as a pediatric surgeon, to speak at a symposium of medical students. In his talk, he describes the relationship between art and science in medicine, and explains his excitement about and concerns for the future.

People who are not physicians have a habit of talking casually about *the medical profession,* but I have yet to come upon any homogeneous group of doctors. I'd like to discuss this idea of differences in the medical profession.

I remember when I was in medical school. It was before the age of antibiotics; I was practicing medicine when penicillin first became available. Howard Florey developed a usable form of the drug in 1940, the year before I graduated from Cornell University Medical College. Most of the penicillin available during World War II was sent to our troops in the Pacific and European battlegrounds. The home front got a small allotment, but not very much. At one point the entire supply of penicillin for the city of Philadelphia was in the small refrigerator in my lab at the Hospital of the University of Pennsylvania. No patient received more than 100,000 units in any 24-hour period.

So much more has changed. A full 90 percent of what medical students learn in medical school is different from what I learned at Dartmouth, Cornell, and the University of Pennsylvania.

That figure is awesome, but I am pleased to report that I have been involved personally in the development of some of the 90 percent that's new. Let me toot my own horn, just a little. For several years I was one of a half dozen surgeons *in the country* who specialized in a new area of medicine: pediatric surgery. I built the first neonatal intensive care unit and was the first physician, as far as I know, to use a polyethylene line intravenously in a patient. I knew it had been used in cats—that's where I got the idea.

There now is positive change in the way medical students and the medical faculty interact. I sense a greater camaraderie among you, a sense of shared mission and mutual respect. In my day, I must confess, there was a high, cold wall between our lives as students and *their* lives as faculty. My fellow students and I stood in fear when we arrived at an appointment with a faculty member. It always seemed that the reason for such an appointment could only be negative—there were no positive or even benign reasons for being called in for a talk. That kind of atmosphere has changed, and for that I say, "Thank goodness." Today, when a student has an appointment with a faculty member, it can be for any number of reasons.

The art of medicine

On the other hand, I believe the physicians of my generation have a stronger sense of the "art" of medicine and give less veneration to the "science" of medicine.

Maybe we feel that way because, when we started, the scientific underpinning for medicine was, to be honest, rather marginal. Let's face it: we practiced medicine without antibiotics. Is that medicine . . . or magic? A little of both, I suppose. But medicine is very much more an art than a science, and I think most of my colleagues felt the same way. As a result, most patients felt that way, too, because in a hundred subtle ways we transmitted our feelings to them.

What is the real significance of the statement "previous generations of doctors practiced the art, rather than the science, of medicine"? Primarily, it means we saw medicine as a relational enterprise. And we asked the kinds of questions that made us more sensitive to the nature of our relationships: How did we react to patients? How did we treat them? How did they respond to us? Did we care about them? Did we care about their families? Did our patients and their families work with us and become our allies against the particular malady affecting the patient?

Those were very important questions for us because we were people-oriented. We *had* to be. It was an attitude born as much of professional necessity as of personal inclination. This was an age without the benefit of PET scans or CAT scans or NMRs or automated analyzers. Everything we learned about our patient came from taking a good history—through sensitive dealings with family members—and through lots of nonstop talk with sympathetic and equally inquisitive colleagues.

That was the fun of medical practice. Every patient was a challenge. And in pediatrics, as many of *you* also know, the challenge is especially difficult.

Today, you have all that technology to help you out. If a patient is uncommunicative for any reason, you're not terribly upset because you'll get most of the information from machines, laboratories, and technicians. No doubt your diagnoses are good; you probably

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This article is based on a speech given to the First Annual Pennsylvania Medical Student Symposium in Philadelphia on March 23, 1985. Dr. Koop is the Surgeon General of the United States.

arrive at them more quickly than we did. But the challenge and the fun of making a difficult diagnosis, quickly and correctly, is gone. The *art* of the thing has been almost wholly sublimated to the *science* of the thing.

Something may have been lost in the process—something very important to the continued strength of the medical profession. I believe that "something" is the human bond, the relationship, between the physician and the patient. Some of today's buzz-words among medical students are "caring," "compassion," "dignity," "humane." Those are among the most beautiful words in the English language, but I'm afraid they are forced to exist alongside some other contemporary buzz-words. Terms like "damage control" and "defensive medicine" and "malpractice"—terms which are among the ugliest in the language.

They are ugly because they convey the very antithesis of caring and compassion. They convey the idea that the patient and the doctor are adversaries—that each one must guard against the surreptitious tactics of the other.

How did this happen? It happened when doctors began to press to their collective bosom every new technological development of the past 20 to 30 years. It happened when physicians began to see science and technology as the heart and soul of medical practice, instead of seeing medical practice as having a heart and soul of its own.

The family doctor

One important influence in my choice of medicine as a career was our family doctor, a man who would have been baffled not only by the term but also by the very concept of "defensive medicine." He was a gentleman—in an era when gentlemen were still considered necessary for a civilized society.

Our doctor came to our house when one of us was ill. When he came, we tiptoed and whispered, not because of his stethoscope, but because we honored and respected him. He was no magician or high priest—he was just a very special person.

What made him special? The fact that he dispensed colorful medicines right in your home, from his little black bag? No, that was not it because most of the time the medicines were ineffective and barely safe.

Was it that he had a degree? In our neighborhood the people who were most respected were those who earned degrees to be teachers, especially college teachers. The medical degree seemed to be a permit to work nights and weekends and have people come to your office whom you would never invite to your home.

Was it that he cured you of what ailed you? Certainly not that. Like his collection of pills and potions, I'm afraid our family doctor—along with so many of his colleagues—was also generally ineffective, and only marginally safe. Everyone alive and my age today can thank mother nature for pulling us through some tough times as children. In most cases, it would be stretching a point to thank the profession of medicine.

Then why did we have such respect for our family doctor? There were several reasons. For one, he cared about us. When we were sick, he came to see what he could do. Not to see "what could be done"—but to see what he, personally, could do. The first thing he did when he got to our house was sit and talk with the patient and with members of the family. He wanted all the details he could get. Then, after a quick and usually accurate diagnosis, he explained in layman's language just what the trouble seemed to be and what he thought we—that is, he, the patient, and the family—could do. He made us his allies in the fight against disease. We weren't just part of the problem: we were part of the solution.

In those days—these are the 1920s and the 1930s—we didn't expect miracles. We hardly expected cures. Nevertheless, we genuinely loved and respected our doctors. Today, we *do* expect miracles, we *do* expect cures, and the public is coming to hate its doctors. Keeping the vision of that family doctor in my mind over the years, I have tried to practice his kind of medicine. I sit and talk with the parents of my tiny patients. We have sweated out the hours together in recovery, and been on the phone together with community agencies to see what kind of help would be there when the family takes the baby home. I have visited them at home and served with them on committees for neighborhood improvement. My patients and their families know me on the same terms that I knew my family doctor.

Has it been worth it? Yes, it has. I have met smart, courageous, generous, compassionate families. I have helped their children overcome a disability, and *they* helped *me* overcome pessimism and defeatism and frustration—feelings

all too common among hard-working physicians.

What else did I learn? Let me tell you what I *did not* learn. I did not learn to fight malpractice cases one after the other while trying to earn a living in medicine. I have never been sued or had to settle a potential suit. My patients and their families were never my adversaries in a court of law. Will I share my secret with you? Well, I already have. My secret—if you want to call it that—is to form a bond with your patients, to confide in them in the way you want them to confide in you, to respect them for being what they are: sensitive, decent, intelligent human beings. Let that opinion be the one that guides you.

Of course, you're going to be disappointed now and then. There are among patients the same percentage of cheats, fools, and blowhards as there are among doctors, or in the population in general. And, depending on your particular practice, you just might draw more than your fair share of deadbeats and malcontents. I'm sorry about that, but it's still no excuse for discarding the key elements of the art of medicine: the element of personal attention and interest; the element of true caring; the element of sincere human feeling; and the element of generosity of spirit.

Where will our priorities lie?

Medical students in this glitzy final quarter of the Twentieth Century have a better chance of healing and curing than any of their predecessors, going back to Aesculapius himself, but medicine is not Silicon Valley and your clinic is not the Redstone Arsenal.

I am concerned about some health professionals, particularly those involved in scientifically uncertain areas. At Humana Hospital in Louisville, Kentucky, the medical and corporate leadership soon realized that William Schroeder would not be the only one to benefit from the artificial heart procedure. A stock analyst at Dillon, Read, the well-known Wall Street brokerage house, said that the Schroeder operation attracted extraordinary press coverage and, therefore, was a priceless advertisement for new patients. A happy thought for many, many Humana stockholders.

Is the way Humana Hospital handled the Schroeder implant the wave of the future? Confronting the spiralling costs of health care, many of us have thoughtfully maintained that competitive, corporate medicine might be more cost-effective and safer for patients. Have we been correct in this judgment?

When I read accounts emanating from the media on "high-tech" medical procedures, my memory goes back to a time when I performed some experimental procedures. I recall, for instance, a newborn with esophageal atresia. When I operated, I found the baby had no lower esophagus at all. This was not a total surprise to me; I had come upon it before and, from time to time, had discussed the problem with colleagues. We had talked about the possibility of interposing a length of colon in just such situations. For that particular baby—born prematurely, weak, and with poor prospects generally—I went ahead and tried, to the best of my ability, to perform the first colon interposition. But it was not a success and the child died.

However, my staff and I learned from that experience. Over the next couple of years, we performed 12 more such operations on children with the same rare disability, a missing esophagus, and we were successful those 12 times.

> 'Form a bond with your patients . . . respect them for being what they are: sensitive, decent, intelligent human beings. Let that be the opinion that guides you.'

At that point, we submitted our findings to a professional journal and waited for the judgments of our colleagues. We made history. However, we made it medicine's traditional way—which is the best way. We did not call up the wire services and the local radio stations for interviews before we scrubbed and stepped into the operating room, and we did not want the press waiting for us and for the patient's family when it was all over either. We were not selling stock . . . we were saving lives.

I think this is one of those profound differences that has come to dwell in the house of medicine. And it is not pleasant to behold. If I were just beginning a career in medicine today, I would be seriously concerned about this for a number of reasons.

First, the commercialism that has begun to tarnish the image of our profession can taint the people in it as well. You ought to worry about that.

Second, the most pervasive government controls and regulations that have appeared in medicine in recent years were put there not for medical reasons but for economic reasons. However, the results can affect the quality of medical care. For example, to control the cost of in-patient care, the complex art of medical diagnosis is now codified into 467 diagnosis-related groups, or DRGs.

Third, we are entering an era when there is supposed to be a glut of practicing physicians. Because of this, doctors and clinics are advertising lower fees for routine medical services—the kind that are the bread and butter, if not the heart and soul, of any community practice. The big money that many physicians have made—the average for the profession is $100,000 a year—may not be available in the future.

Ethical dilemmas

Let me assume the role of prophet for a moment. In the early years of the next century, one in five people will be over age 65. That is a total of 50 million people altogether, and half of them will be over 75. There also will be lots of children—the echo of the echo of the baby boom. How will the toddlers of today foot the bill?

Two ethical issues caught this society by surprise in the last two decades: abortion and Baby Doe. We have 20 years to prepare for the Granny Doe of 2005. But for every one Baby Doe there will be thousands of Granny Does.

Let me review the debate over withholding or withdrawing care for the elderly. There are areas of agreement, areas of disagreement, and areas where policy seems to lag behind practice.

The area of full agreement are: (1) The patient or a suitable proxy (and suitable must be defined carefully) decides about withholding or withdrawing care; (2) Physicians do not kill their patients; (3) Nor do they assist in suicide; (4) There is a real difference between preserving life and prolonging the dying process; (5) The goal of medical practice is not to cure at all costs; (6) Almost any protocol is acceptable to control symptoms when a cure is not available; (7) Brain death in its strictest application is the same as total death; (8) The sanctity and quality of life are factors in patient care; and (9) When in doubt—err on the side of life and care.

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The areas where policy lags behind practice are these: (1) The doctor is responsible for the treatment, prognosis, and explanation of care options; (2) Basic guidelines include benefit vs. burden; (3) Physical life is not the highest good; therefore, death is not the highest evil; and (4) Orders not to resuscitate are compatible with maximal care.

Areas of disagreement include: (1) Once started, a therapeutic regimen must be continued; (2) Food and fluids must always be provided; and (3) Orders not to resuscitate are different from all other options but do not have to be separately ennunciated if the decision of the patient is to treat no further.

No other choice but medicine

Many of the changes and the differences occurring in medicine are right—they are exciting. They are good for medicine and good for our country. For example, we are far more sensitive these days to the health of women than ever before. Today, we are concerned not only about women as child-bearers—the traditional but rather narrow view, but also about women living full lives doing whatever they want to do—follow careers, pursue education, run businesses, have children.

All of us need our health if we wish to pursue our own personal destinies. We are more conscious of the role informed people play in promoting their own good health and in preventing bad things from happening. As Surgeon General, I've called for America to become a smoke-free society by the year 2000, and the response has been extraordinary. We could be a smoke-free society a good bit earlier with no trouble.

In addition, we have become one of the most health-conscious societies in the world. People talk glowingly about the Scandinavians and the British and how they're so concerned about the health of their citizens. They are. But today I think that the citizens of those countries are probably less well informed about exercise and diet and medication and stress than Americans are. Their citizens take fewer personal initiatives in health promotion and prevention than our citizens do.

For those and many other reasons, I envy those starting a career in medicine. I regret some things that are going on—the lack of good doctor-patient relationships, the preoccupation with money and power, the growth of regulation, and so on. But I also know that medicine still offers the individual one of the most satisfying ways to make a life that I have ever encountered. Last summer marked my fiftieth year in medicine. That's a long time. And it's been an exciting and personally rewarding time. Let me assure that I would not trade one minute of all those years to have been doing anything else. □

medical feature

Myelolipomas—is surgery indicated?

A. Georgiades, MD
H. Slater, MD
I. W. Goldfarb, MD

Myelolipomas of the adrenal gland are benign, usually unilateral non-functioning tumors, discovered either at autopsy or incidentally during CT scans or IVPs for some other abdominal indication. Occasionally, patients will present with an abdominal mass, which is accompanied by pain, backache, and fever, as the tumors enlarge and necrose.[1]

The purpose of this paper is to present an unusual case of bilateral myelolipomas with a review of the literature, and to propose a systematic diagnostic approach to benign, nonfunctional tumors of the adrenal gland.

Case report

A 53 year old white male was referred to the Western Pennsylvania Hospital with a history of Parkinson's disease, moderate hypertension, symptomatic coronary artery disease with subsequent coronary artery bypass, and recent onset of non-insulin dependent diabetes mellitus. Two months prior to admission he began to complain of intermittent bilateral flank pain that gradually worsened developing into a persistent dull back pain radiating to his right leg and necessitating medical attention. The patient denied any other contributory symptomatology save for his chronic Parkinson's disease and a left extremity paresis, secondary to an Erb's palsy sustained at birth.

Physical examination revealed an obese male with facial plethora and flushing. The chest was unremarkable. Abdomen showed truncal obesity with dull, bilateral flank tenderness on deep palpation radiating to his right thigh. Extremities showed left upper extremity weakness, atrophy, and flexion contractures. All other systems were negative.

Initial work-up from the referring hospital included a CT scan which disclosed bilateral suprarenal masses, each approximately 11 cm in diameter with a low density matrix consistent with adipose tissue. An IVP revealed a suprarenal mass displacing the upper pole of the left kidney.

An endocrinological work-up was then carried out in view of the patient's history of hypertension, plethoric stature suggesting Cushing's disease, and proximity of the masses to the kidneys and adrenals. This included aldosterone renin, catecholamine, vanillymandelic acid, cortisol, ketosteroid and dexamethasone suppression tests, all of which were within normal limits.

Table 1

Literature Review of Surgically Resected Cases of Myelolipomas of the Adrenal Glands

total no. of cases:	27
age range:	41-72 years
sex—male:	17
female:	10
side predilection rate	
right:	13
left:	12
bilateral:	1
wt. range:	50-1250 grams
size range:	6-30 cm diameter

Ultrasonography then was performed and showed bilateral structures with increased echogenicity consistent with adipose tissue, and shadowing indicative of calcifications. Adrenal angiography followed, revealing a mass effective with hypovascularity and "capping" of the masses by the essentially normal peripheral vasculature. Although the studies of this patient suggested benign, adrenal neoplasms, malignancy could not be ruled out: percutaneous needle biopsy of each of the masses revealed only adipose tissue and hemorrhage.

The patient was subsequently explored through a bilateral, subcostal incision, where the masses were easily identified, closely adherent to the superior posterior aspect of the kidneys, with no visible evidence of normal adrenal glands.

Examination of the resected tumors revealed two well encapsulated, firm, rubbery masses. The left measured 12 × 10.5 × 6 cm and weighed 436 grams. The right measured 11.5 × 11.5 × 5 cm and weighed 380 grams. The external surfaces were smooth, predominantly yellow-tan with focal, poorly demarcated areas of reddish-brown discoloration and abundant fibro-adipose tissue adherent to the surfaces.

On sectioning the masses were yellowish in color with a septate lobular pattern and a consistency of adipose tissue; interspersed were reddish-brown areas resembling hematopoietic tissue.

Microscopically the stroma consisted of varying mixtures of mature fat cells with no evidence of lipoblasts or fetal fat formation, and myeloid elements of lymphocytic, myelocytic, erythrocytic, and megakarycytic cell lines. Beneath the capsule, localized areas of adrenal cortical cells could be identified.

Postoperatively the patient did well with complete relief of his initial complaints and was subsequently discharged on the eighth postoperative day. One year follow-up shows the patient to be alive and well.

Discussion

Myelolipoma of the adrenal gland was first recognized by Gierke in 1905 as an incidental finding at autopsy, but it was not until 1957 when Dyckman and Freedman reported the first symptomatic resected case.[2] Since that time, 25 additional cases have been reported and are summarized in Table 1.

Age ranged between 41-72 years with

The authors are associated with the Western Pennsylvania Hospital, Pittsburgh. Dr. Slater is acting chairman of the department of surgery. Dr. Goldfarb is a surgeon on the hospital's medical staff, and Dr. Georgiades is a resident in surgery.

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no sex or side predilection. Seventeen of the 27 cases were in obese men complaining of vague abdominal pain; hypertension and hematuria were the most common symptoms. It is doubtful that the hypertension and hematuria are related to the tumor itself, but the pain is attributed to visceral displacement, hemorrhage, or necrosis. Generalized non-specific complaints such as weight loss, anorexia, and muscle weakness may also be noted. Twenty out of 27 patients were noted to be obese with chronic illnesses ranging from ostemyelitis to coronary artery disease, diabetes mellitus, hypertension, and severe third degree burns. This may support a theory that these lesions have multiple causes including chronic disease, infections, tissue factors from necrotic tissue, increased secretion of adrenocorticotrophic hormone, and androgenic stimulation with metaplasia of mesenchyma stem cells or reticular stromal cells into myeloid and lipomatous lines. This is supported by Selye and Stone who have experimentally produced myeloid transformation of the adrenal cortex by injecting various hormones and necrotic tumors into rats.[3]

More commonly however, since the initial discovery, approximately 200 cases (0.2% of 2000 autopsies) have been reported in the world literature either at autopsy or as incidental findings by ever increasing refinement of ultrasound and CT studies, and had no relationship to the clinical presentation. These two modalities provide the masses' relative location, size (usually less than 1.5 cm), and probable composition.

Given that most of these asymptomatic adrenal tumors are benign, the question then arises as to the need for surgery on such patients with incidental asymptomatic and undiagnosed adrenal masses.[4] Unfortunately the answer to this question has not been settled, although it is agreed upon that incidental asymptomatic adrenal masses, detected by CT scan or ultrasound should first be ruled out as metastatic disease from another primary site.[5] Having satisfied this, an endocrinological work-up is in order, screening for a functional capacity by measuring urinary VMA, metanephrine, catecholamines, 17-OH corticosteroids, 17 ketosteroids, and plasma cortisol, aldosterone, epinephrine, and norepinephrine. Further diagnostic studies should include an angiogram that would provide the nature of the vasculature and rule out any tortuous neovascularity that would be indicative of malignant growth.[6] A benign mass, such as a myelolipoma would display only adrenal vessels with occasional vascular "capping" of the mass.

Although perhaps not indicated for large symptomatic or functional tumors, where surgery is indicated, a CT guided needle biopsy may be useful for patients with an asymptomatic, nonfunctional adrenal mass.

After a complete and thorough evaluation still reveals an asymptomatic nonfunctional mass, therapy can be individualized.

With the ability to perform guided needle biopsy of non-functional adrenal masses, unnecessary operations can be avoided. □

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Generic substitution resulting in toxicity

Albert J. Finestone, MD
Frank F. Williams, PhD

We recently saw a patient whose problem illustrated some of the possible dangers of generic substitution due to difference in bioavailability.

Case report

The patient, aged 75 was admitted to Temple University Hospital for treatment of ataxia noted over the previous 24 hours. The patient had a seizure disorder following a CVA in the past. She had been well controlled on 200 mg of Dilantin Kapseals (Parke-Davis) b.i.d. Examination showed nystagmus and ataxia with a dilantin level of 44.2 mg% (top normal 20 mg%). When questioned about a change in medication, the patient said the appearance of the drug was different when she renewed her prescription 10 days prior to her admission. With discontinuation of the drug, her symptoms resolved and the dilantin level approached the therapeutic level. She was discharged on the previous dose of Dilantin.

Comment

In Pennsylvania the P.A.C.E. program (Pharmaceutical Assistance Contract for the Elderly) assists elderly patients below a certain income with the costs of prescription drugs. Generic substitution is encouraged unless the physician specifies non-substitution. Most physicians probably do not realize that generic phenytoin has a more rapid rate of dissolution and is really a different drug from Dilantin Kapseals which have a relatively slow rate of dissolution and extended delivery. Therefore, there is considerable risk in freely substituting prompt phenytoin sodium capsules for extended phenytoin sodium capsules. This could result in acute phenytoin intoxication, as occurred in our patient, or in sub-therapeutic phenytoin levels.

Physicians are therefore advised to consider bioavailability difference between generic and non-generic pharmaceutical products before allowing substitution. Pharmacists should monitor this aspect of their professional responsibility very closely. □

The authors are associated with Temple University. Dr. Finestone is clinical professor of medicine and associate dean for continuing medical education at Temple University School of Medicine, and Dr. Williams is assistant director of pharmacy at Temple University Hospital.

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The maldistribution of Pennsylvania's physicians—by geographic region and by specialty—has been identified as a major health care problem over the past few decades. Ten years ago, the Commission on Education and Manpower of the Pennsylvania Medical Society issued a physician manpower report that concluded, "there is a shortage of primary care physicians" and "an uneven distribution of physicians across the state." In an attempt to respond to these problems, officials at Jefferson Medical College of Thomas Jefferson University chose to intervene in the medical school's admissions process as well as to effect some changes in the medical school curriculum.

Once the decision had been reached to intervene at the admissions selection level, the next step was determining what form this intervention should take. At least two questions needed to be addressed: what factors influence a future physician's decision to practice in a rural or physician shortage area? and how could the medical school gauge the existence of these factors in a prospective medical student's personal or academic profile? An extensive search of the existing literature was undertaken to seek answers to these questions. Based on this research, two courses of action—selecting students raised in a rural area and limiting the intended specialty choice to family medicine—were identified as means for increasing the number of primary care doctors who choose rural locations.

The most convincing data from this review of the literature indicated doctors preferred to practice in communities similar in size to those in which they had been raised. It appeared that overall, medical students, residents, and physicians who grew up in a rural environment eventually were more likely to practice in rural areas than were peers raised in urban settings. Other data indicated that physicians whose specialty training had been in family medicine were three times more likely to practice in non-metropolitan areas than were other primary care physicians.

Furthermore, the combination of these two factors, a physician's non-metropolitan background and the specialty choice of family medicine, had a cumulative effect. Two-thirds of this group went on to practice in rural areas whereas physicians raised in cities who selected family medicine training, as well as physicians from a non-urban background who selected specialties other than family medicine (including those in the other primary care specialties of internal medicine, pediatrics, and obstetrics/gynecology), did not have an increased likelihood of rural practice. The data provided evidence that a larger percentage of family physicians actually provide primary care and provide that care for a greater proportion of their practice time, than do other primary care specialists who are more frequently involved in subspecialty care.

These data, therefore, suggested that if the desired outcome was to increase the number of primary care physicians in rural areas, there was a statistically greater chance to achieve this goal by training physicians raised in rural areas in family medicine. Though it was a relatively easy task to select applicants to medical school who were raised in rural areas, little information was available to identify which, if any, admissions criteria would predict a future specialty choice of family medicine. On the contrary, one well documented fact was that medical students tend to change their career/specialty choices during the course of their training.

Studies also have shown that in particular, the number of students planning to enter family medicine traditionally has decreased as students progressed through their undergraduate medical educations. In a prospective study from 1948-1964, however, the University of Illinois College of Medicine developed a special program giving preferential admission status to rural students and this program was successful in increasing both the percentage of physicians practicing in rural Illinois as well as the number of students entering general practice. Of concern was the fact that 13 percent of the participants in this program had been dismissed for academic reasons during medical school. The challenge for Jefferson Medical College was to repeat the success of the program at University of Illinois while avoiding the high student failure rate.

The authors are associated with Jefferson Medical College of Thomas Jefferson University. Dr. Rabinowitz is clinical associate professor of family medicine, and Ms. Henick is educational coordinator for the department of family medicine.

Program description

Beginning in 1974, and concomitant with the development of the Department of Family Medicine at Jefferson Medical College, the Physician Shortage Area Program (PSAP) was developed in order to identify medical student applicants who would eventually practice family medicine in physician shortage areas (primarily rural areas in Pennsylvania). Initially, 12 places for admission to the first year class were reserved for applicants to the program. In 1978, the number of places in the program increased to a maximum of 24, representing approximately 10 percent of the entering class of 223 students. This increase allowed for some of the potential spaces to be reserved for applicants from Indiana University of Pennsylvania under the Cooperative Family Medicine Physician Education Program. Students who applied to the PSAP were placed in a special applicant pool, and were evaluated by a subcommittee of the Committee on Admissions, whose recommendations were sent to the full Committee on Admissions for final action. Students were judged by the same parameters as those in the regular applicant pool, and only students who were academically qualified were accepted.

Applicants to the program were given high priority only if they lived, grew up, or had strong family or personal ties in or adjacent to a medically underserved or physician shortage area of Pennsylvania (documented by the Pennsylvania

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Department of Health or designated as a Primary Care Health Manpower Shortage Area), had three personal letters of recommendation from citizens in their community, and were judged at the time of interview by a member of the Committee on Admissions to have a strong commitment toward abiding by their intent to practice family medicine as a future specialty in an underserved area. Financial aid in excess of that routinely given to Jefferson students also was offered.

Upon entering the PSAP, students were required to make four commitments. They were asked to take their required junior family medicine rotation at the Jefferson affiliated family practice centers at Latrobe Area Hospital or Franklin Hospital because these locations were most similar to the underserved areas where most of the students were expected to practice. (Each of Jefferson's third year students is required to take a six-week family medicine clerkship at one of six family practice centers.) They were asked to take a family medicine preceptorship as their senior ambulatory clerkship. (All senior students are required to participate in an ambulatory clerkship in either family medicine, internal medicine, psychiatry, or pediatrics.) They were asked to take a three-year family medicine residency and to practice family medicine in a physician underserved area, preferably in Pennsylvania, on completion of their family medicine residency training. Faculty members in the Department of Family Medicine were made available as advisors throughout the four years for those students admitted to the PSAP.

Ten years later

In 1985, most health care experts still believe that the maldistribution of physicians remains a major health care problem in this country. While the GMENAC report has predicted an oversupply in the total number of physicians in the future, it continued to emphasize the serious lack of primary care doctors in rural areas. And while primary care medicine is shared by specialists in family medicine, internal medicine, and pediatrics, rural primary care continues to be provided primarily by family physicians and general practitioners.

During the past decade, the PSAP has added significantly to our knowledge in this area. 177 students have been admitted to the PSAP since 1974. 116 of these students (66%) have come to Jefferson from Pennsylvania's 37 non-metropolitan counties (non-Standard Metropolitan Statistical Area counties), which in 1975 contained only 14% of the state's primary care physicians (general practitioners, family physicians, internists, and pediatricians—although 78% of this group were general practitioners and family physicians). The remaining 34% of students came from physician shortage areas within SMSA counties. These students who have been admitted to Jefferson through the PSAP, therefore, have represented a dramatically different geographical background than the remaining traditional medical school class, with its heavily urban representation.

The academic admission parameters of the PSAP students who have been accepted to Jefferson have been similar to that of their peers in mean undergraduate grade point averages for science (PSAP 3.46 vs. non-PSAP 3.53) and non-science courses (PSAP 3.52 vs. non-PSAP 3.54), as well as their mean Medical College Admission Test (MCAT) scores (old MCAT: PSAP 590 vs. non-PSAP 608; new MCAT: PSAP 9.3 vs. non-PSAP 10.0). Similarly, a 1981 evaluation of the program showed that the PSAP students performed in an equivalent manner to their peers during medical school, as measured by their attrition rate (PSAP 4.1% vs. non-PSAP 2.5%), grade point average (PSAP 83.1 vs. non-PSAP 83.9), and the examination of the National Board of Medical Examiners, Parts I (PSAP 490 vs. non-PSAP 521) and II (PSAP 515 vs. non-PSAP 532).

After seven graduating classes in the program—for a total of 109 graduates—61 percent of the PSAP graduates have entered family medicine residency programs. (An additional 17 percent have entered postgraduate training in internal medicine or pediatrics.) This entry rate of PSAP graduates into the specialty of family medicine represents a rate five times that of the rest of their classmates and almost twice the rate of a comparable group of non-PSAP students who originally entered Jefferson with plans of becoming family physicians. The PSAP, therefore, has supported the concept that a group of students can be preselected at the time of medical school admission who, because of their rural background and commitment to family medicine will eventually enter family medicine as a career. While long-term follow up of the PSAP graduates is currently being planned to determine their eventual practice locale, a high proportion can be expected to be located in rural areas because of their rural background.

Discussion

During the past decade, further clarification of those clinical specialties and geographical areas which are underserved has taken place in the United States. Despite current projections that overall, fewer physicians will be needed in the future, a major priority continues to be increasing the number of primary care physicians in rural areas. The PSAP has aided in this effort. The program has successfully increased the number of Jefferson graduates entering family medicine residency training programs in particular, as well as increasing the number of students going on to primary care residency training programs in general.

This success, however, has not been without certain obstacles. Over the course of the past ten years, some difficulty has occurred in attracting to the program a large enough pool of applicants from rural Pennsylvania. Specifically, this decline in the number of applicants has coincided with the narrowing of the definition of what comprises a physician shortage area. Guidelines have shifted from defining entire counties, to specifying particular sections of counties (e.g., census tracts and towns) that can be considered physician shortage areas. This modification has led to an obvious decline in the number of academically qualified college graduates seeking medical school admission who originate from these regions. Therefore, as a reasonable compromise to offset this shrinking applicant pool, Jefferson officials chose in 1983 to use non-SMSA counties as a general guideline for defining rural underserved areas of Pennsylvania. While this non-SMSA designation does not perfectly equate with either rural or medically underserved areas, these counties are rural and the vast majority of physician shortage areas are located here.

Feedback from the PSAP students themselves shows that most students have been satisfied with the admissions and educational components of the program, though many have had expectations for increased financial aid. Improvements in this area, as well as in loan forgiveness, appear to be needed.

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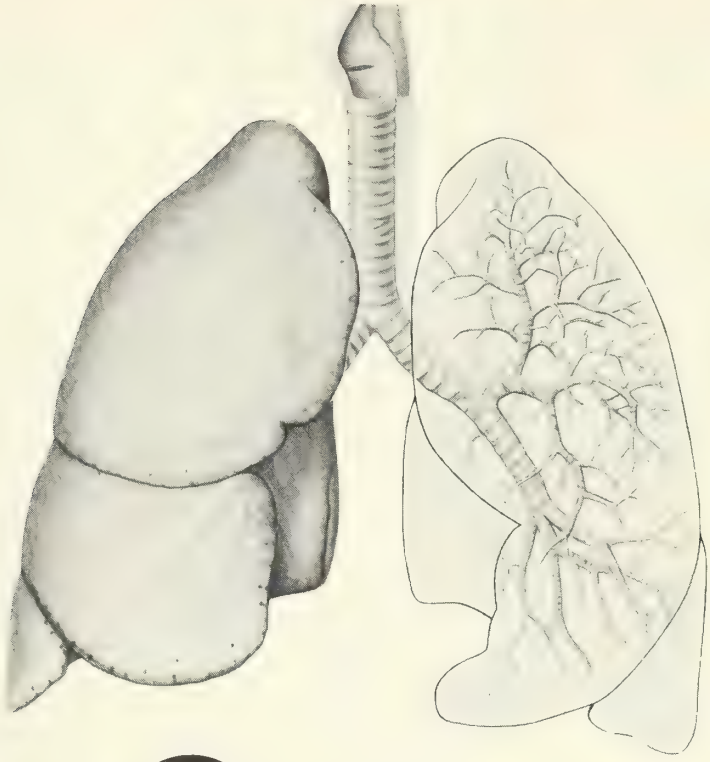

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

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Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

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Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

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Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

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[061782R]

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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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physicians in the news

Gordon K. MacLeod, MD, Pittsburgh, has been appointed to the American Medical Association's Study Committee for a Section on Faculty and Research. The committee was formed at the request of the national organization's house of delegates.

The Medical College of Pennsylvania (MCP) has received a $450,000 gift from the William Penn Foundation of Philadelphia. **Maurice C. Clifford, MD,** president of the medical school, said the grant will be used to develop MCP's emergency medical services program. **David K. Wagner, MD,** professor and chairman of the department of emergency medicine said the funds will enable the institution to expand emergency services and the educational training program.

John H. Glick, MD, has been named director of the University of Pennsylvania Cancer Center. Dr. Glick was previously professor of medicine in the section of hematology-oncology at the University of Pennsylvania School of Medicine and he served as the center's associate director for clinical research.

Peter A. Keblish, MD, an orthopedic surgeon from Allentown, presented a paper on knee replacement at the Eleventh Annual Meeting of the Orthopedic Surgery and Trauma Society in Bonaire, Netherlands Antilles. The paper, which was published in the journal *Orthopaedic Transactions* earlier this year, was awarded the Emmett Lunceford Scientific Award at the meeting.

William E. Staas Jr., MD, Cherry Hill, New Jersey, has been elected fourth vice president of the American Congress of Rehabilitation Medicine. Dr. Staas is medical director of Magee Rehabilitation Hospital, Philadelphia.

Alan R. Forman, MD, has been named associate surgeon on the General Ophthalmology Service at Wills Eye Hospital, Philadelphia. Dr. Forman also serves as a clinical instructor at Jefferson Medical College of Thomas Jefferson University.

Lila Stein Kroser, MD, Philadelphia, was a participating faculty member at the Second Midwest Regional Conference on Women in Medicine in Kansas City, Missouri. The program was sponsored by the University of Kansas College of Health Sciences and Hospital, the University of Missouri—Kansas City School of Medicine, and the American Medical Women's Association. Dr. Kroser is immediate past president of the American Medical Women's Association. In addition, Dr. Lila Kroser and **Albert Kroser, MD,** recently returned from a series of medical seminars in the Soviet Union. They served as education leaders for a group of American physicians on the tour.

Robert L. Goodman, MD, and **Gerald E. Hanks, MD,** both of Philadelphia, hold offices in the American Society for Therapeutic Radiology and Oncology. Dr. Goodman was elected treasurer and Dr. Hanks is immediate past chairman of the Board of Directors.

Arnold T. Berman, MD was elected to the Board of Trustees of Hahnemann University, Philadelphia. Dr. Berman is professor and chairman of the department of orthopedic surgery and rehabilitation at Hahnemann.

Bruce A. Cohen, MD, a family practitioner in Birdsboro, has been selected as an Outstanding Young Man of America for 1985.

William H. Mahood, MD, recently was elected president of the Pennsylvania Society of Gastroenterology. He will serve for the 1986-87 term with fellow officers **S. Phillip Bralow, MD,** Philadelphia, president elect; **Morton Goldstein, MD,** Pittsburgh, secretary; and **Michael M. Geduldig, MD,** Harrisburg, treasurer. The elections took place at the annual meeting of the society held in September at the Westin William Penn in Pittsburgh.

special feature

Informal discussions with PSAP students have also revealed that many desire more exposure during medical school to family medicine in actual physician shortage areas (summer experiences and outside speakers). On the other end of the spectrum, PSAP students who eventually chose residency training programs in specialties other than family medicine, were critical of the program because they were required to comply with the undergraduate family medicine curriculum despite their change in career plans.

The evidence suggests that future studies regarding the PSAP are important. Continued follow-up of PSAP students' performance at the postgraduate level is already being planned. In addition, specific factors, such as undergraduate college, undergraduate major, and spouse's background, will be evaluated to identify criteria which, when present, increase the likelihood of PSAP students practicing family medicine and locating in rural areas. In this manner, future applicants can be selected more carefully and the proportion who comply with the program's requirements can be increased even further. Lastly, a large scale follow-up of PSAP graduates regarding their future practice locale will be undertaken in the spring of 1986, using a sample of their non-PSAP peers as a control group.

The shortage of primary care doctors in rural areas remains as serious a problem now as it was ten years ago. The PSAP, along with previous literature, has supported the concept that a special medical school admissions and educational program could be developed which has the potential to increase the number of rural primary care physicians in Pennsylvania three to five times. Using this information on a state-wide basis in order to address the maldistribution of physicians in Pennsylvania is an important issue which demands appropriate attention. □

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Amitabha Mitra, MD, Plastic Surgery, 17205 Delaire Landing Road, Philadelphia 19114
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Estrella A. Ronsayro, MD, General Surgery, 1531 Morris Street, Philadelphia 19145
Robert P. Ruggiero, MD, General Surgery, 100 East Lehigh Avenue, Philadelphia 19125
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Leonard I. Silverstein, MD, Urological Survey, 227 North Broad Street, Philadelphia 19107
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William M. Unwin, MD, Obstetrics/Gynecology, Hospital University of PA, Dept. Ob/Gyn 3400 Spruce St., Philadelphia 19104
Annapoorna Varada, MD, Anesthesiology, Episcopal Hospital, Front Street and Lehigh Ave., Philadelphia 19125

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Ericha R. Benshoff, 5720 Wissahickon Avenue, Apartment B-5, Philadelphia 19144
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Marc R. Federman, 2809 West Queen Lane, Philadelphia 19129
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Cynthia K. Hindman, 3331 Indian Queen Lane, Philadelphia 19129
Brenda K. Jenkin, 250 South 13th Street, Apt. 11C, Philadelphia 19107
Stacey Kaplan, 3120 School House Lane, Franklin Bldg., Apt. B-2, Philadelphia 19144
Jodi D. Kaufman, 3120 West School House Lane, Apt. FB-2, Philadelphia 19144
Scott L. Kay, 1520 Spruce Street, #101, Philadelphia 19102
Kendra B. Kaye, 3445 Vaux Street, Philadelphia 19129
Paul A. Kunkel, 8201 Henry Avenue, Apt. S-22, Philadelphia 19128
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Glenn A. McGrath, 110 Peach Avenue, Hershey 17033
Patricia L. Meinhardt, 5500 Wissahickon Avenue, Apartment 805-B, Philadelphia 19144
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Lauren E. Sales, 3445 Vaux Street, Philadelphia 19129
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Pennsylvania — Emergency physician system. Needs several fulltime emergency physicians for Western Pennsylvania area emergency departments. Independent contractor arrangements. The system is on a "fee-for-service" basis. Contact: (412) 228-3400 for interview appointment.

NEEMA Emergency Medical — a professional association. Emergency medicine positions available with emergency physician group in PA, NY, NJ, VA, WVA, MD, KY, and throughout New England, the Southeast, and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physicians department directors also desired. Please send resume to: NEEMA Emergency Medical, Suite 400, 399 Market Street, Philadelphia, PA 19106 or phone (215) 925-3511 in PA, or (800) 523-0776 outside PA.

Psychiatrist — Board certified or Board eligible. Mental hospital in metropolitan area. Easy access to New York, Philadelphia, and close to Pocono resort area. Good salary with excellent fringe and retirement benefits. Pennsylvania license required. Contact Mrs. Kathleen D. Reese, ACSW, Superintendent, Clarks Summit State Hospital, Clarks Summit, Pennsylvania 18411; (717) 586-2011.

Emergency physicians — Emergency medicine opportunities available for career oriented medical directors and staff physicians licensed in Maryland and/or Pennsylvania. Full and part-time positions available. Applicants must have a minimum of 2 years recent experience. Competitive income and malpractice insurance provided. Please send CV to Sally Bowen at 6227 Executive Blvd., Rockville, MD 10852, or call (301) 984-0353.

Northwest Pennsylvania — Immediate directorship available at moderate volume hospital in summer and winter resort area. Attractive compensation with malpractice insurance provided. Please submit resume to Emergency Consultants, Inc., 2240 South Airport Road, Room 27, Traverse City, MI 49684; or call 1-800-253-1795 or in Michigan 1-800-632-3496.

Desirable central Pennsylvania location — otolaryngologist (ear, nose, throat surgeon). Solo practice with cross coverage available. American Board affiliation required. Area has recreational advantages. Assistance available. Write to Box 134, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Internist with primary care orientation to join rapidly growing solo practice in northwest Philadelphia. Send letter and CV to Box 137, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Unique Opportunity in Pennsylvania—Building new emergency department in progressive, adacemic community hospital. New facility, in-the-round. Base station, active paramedic training program, resident education. Opportunities for research and teaching affiliation with nationally prominent emergency medicine residency program. Competitive salary with paid malpractice, disability, life insurance, CME, etc. Emergency residency trained, Board certified or Board qualified and actively seeking certification. Contact Nathan C. Schafer, MD, Chariman, Department of Emergency Medicine, St. Margaret Memorial Hospital, 815 Freeport Road, Pittsburgh, PA 15215; (412) 784-4189 or 4782.

Neurosurgeon — Excellent opportunity for Board certified or Board eligible neurosurgeon to establish a private practice affiliated with a medium-sized, progressive, acute-care hospital located in northeastern Pennsylvania. Significant growth opportunities available. Generally located between two major

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Pediatrics—Colorado—Convenience of a group. Strong finances.
Radiology—Philadelphia—Large, well-established.
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cities and in close proximity to a variety of ski resorts. Send curriculum vitae and references to Box 138, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Pennsylvania — An additional Board-prepared or certified physician is needed to complete an emergency medicine group at a 308-bed hospital. Please send your resume to Robert H. Spratt, MD, Chairman, Department of Emergency Medicine, Holy Redeemer Hospital and Medical Center, 1648 Huntingdon Pike, Meadowbrook, PA 19046.

Ob-Gyn, Board-certified, minimum 3-years experience, desired to join busy ob-gyn practice in Bucks County, Pennsylvania. Please send curriculum vitae to Post Office Box 401, Newtown, PA 18940.

Full-time opportunity available immediately for qualified physician to work in busy emergency department of 155-bed community hospital located in central PA, home of Bucknell University. Excellent schools, recreational, and cultural activities. Send CV to Administrator, Evangelical Community Hospital, Lewisburg, PA 17837.

Ob-gyn — BE/BC physician needed July 1986 or sooner to join established practice in Philadelphia. Excellent salary, fringe benefits, incentive program. Reply to Box 139, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Orthopedic surgeon to work in expanding pain center, part-time, N.E. Philadelphia. Call (215) 464-1516.

Part-time and temporary positions — Choose from part-time and temporary practice opportunities located throughout Pennsylvania in the new Locum Tenens Section of the Pennsylvania Medical Society's Physician Placement Service. For more information, contact Tim Smith, PMS Physician Placement Service, 20 Erford Road, Lemoyne, PA 17043; (717) 763-7151.

Internist or general practitioner — Unique opportunity exists to establish a practice in a fast-growing community of 30,000+ with low overhead structure. Area located near the ocean and within two hours of Philadelphia and Baltimore. Opportunity available immediately. Send inquiries to: J. Stokes, P.O. Box 809, Milford, DE 19963.

Neonatologist, BC, BE. Unopposed virgin practice available in near future; please write to P.O. Box 401, Newtown, PA 18940. Send CV, we need you soon.

Physician group seeks EM/FP/IM physician for unique rural family practice/urgent care center. FP is located one hour north of Philadelphia. Needs physician for 20-30 hours/week. Hospital patients covered or cover them yourself. Minimum salary guaranteed or sub-let practice with/without option to buy. Shifts available at nearby urgent care center at $35.00/hour. Contact Joseph Balavage (717) 823-0499.

Otolaryngologist — Pennsylvania health care center seeking the services of a full-time ENT specialist to establish practice in our service area. Multiple recreational and educational opportunities available. Send CV to Box 145, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Pediatrician — Practice opportunity available in our community located in northeastern Pennsylvania for a Board certified or Board eligible pediatrician. If you can appreciate a country style of living and yet be close to major metro areas, we'd like to talk to you. Send CV to Box 146, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Internists — Board eligible or Board certified to join the staff of a 150 bed hospital in Pennsylvania. Educational opportunities available as well as abundant outdoor recreation. Send CV to Box 147, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Urologist — Pennsylvania hospital with service area of 40,000 needs the service of a full time urologist. Candidates should be Board certified or Board eligible. Ideal location for family with good schools and many educational and recreational opportunities. Send CV to Box 148, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Dermatologist — Practice opportunity available for a Board certified or Board eligible physician in eastern Pennsylvania. Send CV to Box 149, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Psychiatrist — A country practice awaits you. Join the staff of a progressive community hospital and long term care facility. Board certified or Board eligible. Our Pennsylvania location offers some of the finest outdoor recreation available. Send CV to Box 150, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Radiologist, full or part-time for private practice. General radiology, CT, and ultrasound. Nuclear medicine background helpful. Send resume to Box 143, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

State College, PA — Newly constructed 92 bed free-standing private psychiatric hospital requires two psychiatrists to join its staff. One position is the Director of Adolescent Services. The other is as a unit psychiatrist for the adult services. The hospital is eclectic in orientation but with a strong psychodynamically-oriented milieu program. State College is the home of Penn State University, offering a delightful mix of cultural, intellectual, and recreational activities. The total income package, including salary, a guarantee, and fringe benefits, is substantial. Call or send CV to Magnus Lakovics, MD, Medical Director, The Meadows Psychiatric Center, R.D. #1, Box 259, Centre Hall, PA 16828. (814) 364-2161.

Position open — General surgeon. Experience in non-cardiac thoracic and vascular surgery desirable. Join a group of three established surgeons in a Pennsylvania community. New 500 bed hospital, near major metropolitan area. Prefer long-term commitment to practice, but will consider shorter term. Reply to Box 152, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Family practice physician — wanted full time for three-physician primary care center located 30 miles west of Pittsburgh. OB preferred but not necessary. Position available Spring 1986, but will consider earlier starting date. Send CV to: Henry Levith, Administrator, Community Medical Center of NW Washington County, P.O. Box 167, Burgettstown, PA 15021; or call (412) 947-2255.

Internist/family practitioner — Board eligible or Board certified. Wanted to join busy and rapidly expanding practice in Philadelphia's city line/main line area. Essentially general medicine with an emphasis on geriatrics. Eventual partnership. Position available immediately, but will consider waiting until June if you are currently finishing your residency. Please send letter and CV to Box 151, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

Opportunity for orthopedic surgeon. Board certified in orthopedic surgery. Multi specialty group, salary plus percentage. Size of community: 10,000 - 30,000. Size of trade area: 30,000 - 100,000. Respond to PMS Physician Placement Service, Department NON-0486-SO10, 20 Erford Road, Lemoyne, PA 17043.

Health services position available July 1986. Opportunity for family/general practitioner Board certified in family practice. Responsibilities include supervision of several part-time physicians, one athletic trainer, four full-time and three part-time nurses, and the administration of a sixteen bed health center. Candidate must show a strong desire to work with college-age youths. Salary plus mandated bonus. Excellent fringe benefits. Respond to PMS Physician Placement Service, Department NON-0486-FP82, 20 Erford Road, Lemoyne, PA 17043.

Opportunity for family practitioner. Board certified in family practice with strong interest in obstetrics. Multi specialty group, salary plus percentage. Size of community: 10,000 - 30,000. Size of trade area: 30,000 - 100,000. Respond to PMS Physician Placement Service, Department NON-0486-FP83, 20 Erford Road, Lemoyne, PA 17043.

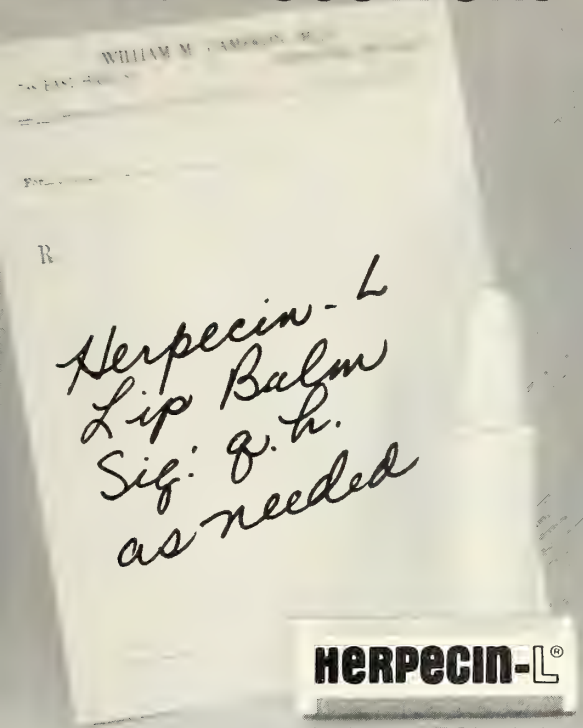
Opportunity for orthopaedic surgeon. Board certification preferred but not mandatory. Solo or partnership, fee for service—minimum guarantee. Size of community and trade area: 100,000 and greater. Respond to PMS Physician Placement Service, Department NOM-0486-SO09, 20 Erford Road, Lemoyne, PA 17043.

Opportunity for family practitioner. Board certified or eligible in family practice. Prefer someone with obstetrical interest and experience but not mandatory. Must have a strong personal interest in patients and enjoy a rural practice. Partnership/single specialty group, salary plus percentage. Size of community: less than 1,000. Size of trade area: 30,000 - 100,000. Respond to PMS Physician Placement Service, Department NOM-0486-FP39, 20 Erford Road, Lemoyne, PA 17043.

POSITIONS WANTED

Part-time and temporary practice opportunities — List your part-time or temporary

Dx: recurrent herpes labialis



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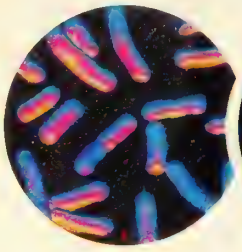
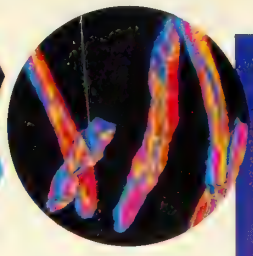
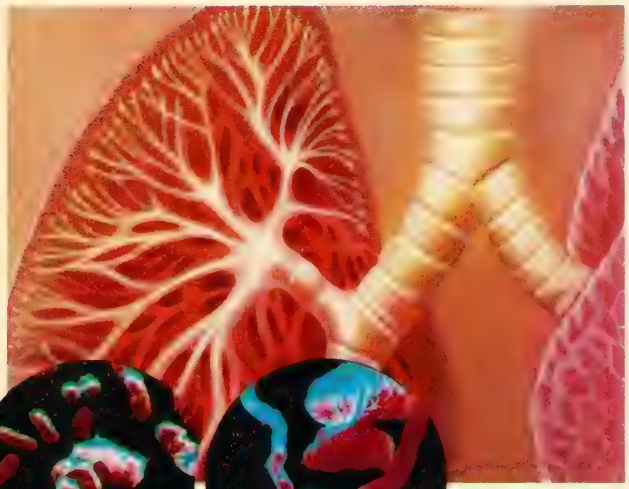
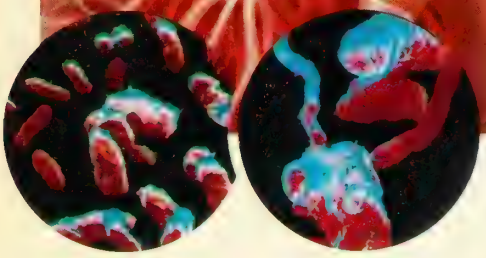




before *E. coli* culture—color-enhanced scanning electron microscopy (SEM).

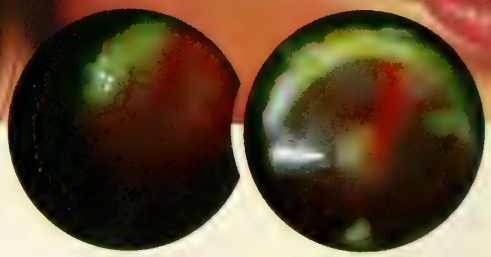
after *E. coli* destroyed by Bactrim 5 × MIC *in vitro*. (*In vitro* data do not necessarily correlate with clinical results.)





before *H. influenzae* culture—color-enhanced SEM.

after *H. influenzae* destroyed by Bactrim 5 × MIC *in vitro*. (*In vitro* data do not necessarily predict clinical results.)



before Otoscopic view of tympanic membrane in a patient who did not respond to ampicillin therapy.

after Same patient after ten days of Bactrim therapy.

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